IOWA Health and Human Services

Request for Prior Authorization
BIOLOGICALS FOR INFLAMMATORY BOWEL DISEASE

FAX Completed Form To
1 (800) 574-2515
Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is required for biologicals used for inflammatory bowel disease. Request must adhere to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations. Payment for non-preferred biologicals for inflammatory bowel disease will be considered only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent. Payment will be considered under the following conditions:

1. **Patient has a diagnosis of moderate to severe Crohn's Disease; or**
2. **Patient has a diagnosis of moderate to severe Ulcerative Colitis; and**
3. **Medication will be administered in the patient's home by patient or patient's caregiver.**

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Preferred

- ☐ Adalimumab-aacf
- ☐ Adalimumab-adbm
- ☐ Adalimumab-fkjp
- ☐ Humira
- ☐ Pyzchiva
- ☐ Simlandi
- ☐ Simponi
- ☐ Skyrizi Auto-Injector
- ☐ Skyrizi Cartridge
- ☐ Skyrizi Prefilled Syringe
- ☐ Tremfya
- ☐ Yusimry

Non-Preferred

- ☐ Cimzia Prefilled Syringe
- ☐ Entyvio SQ Pen Injector
- ☐ Omvoh Auto-Injector
- ☐ Stelara
- ☐ Zymfentra
- ☐ Other Humira Biosimilar: _____
- ☐ Other Stelara Biosimilar: _____

Strength	Dosage Instructions	Quantity	Days Supply
_____	_____	_____	_____

Diagnosis:

☐ **Moderate to Severe Crohn's Disease**

☐ **Moderate to Severe Ulcerative Colitis**

Will medication be administered in the patient's home by patient or patient's caregiver? ☐ **Yes** ☐ **No**

Possible drug interactions/conflicting drug therapies/other medical conditions to consider: _____

_____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary, by contact with the county Department of Health and Human Services, that the member continues to be eligible for Medicaid.*