

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 _ _ _ _ _ _ _ _ _ _

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

☐	Actemra
☐	Avtozma
☐	Bimzelx
☐	Cimzia Prefilled Syringe
☐	Cosentyx
☐	Ilaris
☐	Kevzara
☐	Orencia Prefilled Syringe
☐	Stelara
☐	Other Humira Biosimilar: _____
☐	Other Stelara Biosimilar: _____

Days Supply

Drug Name & Dose: _____ Trial dates: _____
Failure reason: _____

Request for Prior Authorization
BIOLOGICALS FOR ARTHRITIS
(PLEASE PRINT – ACCURACY IS IMPORTANT)

☐ **Psoriatic arthritis, moderate to severe; with**

Documentation of a trial and inadequate response, at a maximally tolerated dose, with methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated).

Drug Name & Dose: _____ Trial dates: _____
Failure reason: _____

☐ **Juvenile idiopathic arthritis with oligoarthritis; with**

Documentation of a trial and inadequate response to intraarticular glucocorticoid injections and methotrexate at a maximally tolerated dose (leflunomide or sulfasalazine may be used if methotrexate is contraindicated).

Intraarticular Glucocorticoid Injections: Drug Name & Dose: _____ Trial dates: _____
Failure reason: _____

Plus methotrexate or preferred oral DMARD trial: Drug Name & Dose: _____
Trial dates: _____ Failure reason: _____

☐ **Polyarticular juvenile idiopathic arthritis (pJIA), moderate to severe; with**

Documentation of a trial and inadequate response, at a maximally tolerated dose, with methotrexate (leflunomide or sulfasalazine may be used if methotrexate is contraindicated).

Drug Name & Dose: _____ Trial dates: _____
Failure reason: _____

☐ **Systemic juvenile idiopathic arthritis (sJIA)**

Reason for use of Non-Preferred drug requiring prior approval: _____

Other medical conditions to consider: _____

Attach lab results and other documentation as necessary.

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