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
- ☐ Amjevita 40mg/0.4mL
- ☐ Amjevita 80mg/0.8mL
- ☐ Humira
- ☐ 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: _____

| 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.*