

BIOLOGIC IMMUNOMODULATORS PRIOR AUTHORIZATION REQUEST PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit www.myprime.com. Start saving time today by filling out this form electronically. Visit covermymeds.com to begin using this free service.

What is the priority level of this request?

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient’s life, health or ability to regain maximum function

Today’s Date: _____

PATIENT AND INSURANCE INFORMATION		Date of Service (if differs from Today’s Date): _____	
Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:		Group Number:	

PRESCRIBER/CLINIC INFORMATION			
Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:		Clinic Address:	
City, State, Zip:		Phone #:	Secure Fax #:

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient’s Diagnosis:	
<input type="checkbox"/> Active ankylosing spondylitis (AS) <input type="checkbox"/> Active non-radiographic axial spondyloarthritis (nr-axSpA) <input type="checkbox"/> Active systemic juvenile idiopathic arthritis (SJIA) <input type="checkbox"/> Cytokine Release Syndrome (CRS) <input type="checkbox"/> Giant Cell Arteritis (GCA) <input type="checkbox"/> Moderate to severe atopic dermatitis (AD) <input type="checkbox"/> Moderate to severe plaque psoriasis (PS) <input type="checkbox"/> Moderately to severely active rheumatoid arthritis (RA) <input type="checkbox"/> Neonatal Onset Multisystem Inflammatory Disease (NOMID) <input type="checkbox"/> Polymyalgia rheumatica (PMR) <input type="checkbox"/> Systemic Sclerosis-associated Interstitial Lung Disease (SSc-ILD) <input type="checkbox"/> Other (ICD code, plus description): _____	<input type="checkbox"/> Active enthesitis related arthritis (ERA) <input type="checkbox"/> Active psoriatic arthritis (PsA) <input type="checkbox"/> Cryopyrin Associated Periodic Syndrome (CAPS) <input type="checkbox"/> Deficiency of IL-1 Receptor Antagonist (DIRA) <input type="checkbox"/> Juvenile psoriatic arthritis (JPsA) <input type="checkbox"/> Moderate to severe hidradenitis suppurative (HS) <input type="checkbox"/> Moderately to severely active Crohn’s disease (CD) <input type="checkbox"/> Moderately to severely active Ulcerative colitis (UC) <input type="checkbox"/> Polyarticular juvenile idiopathic arthritis (PJIA) <input type="checkbox"/> Severe alopecia areata (AA) <input type="checkbox"/> Uveitis

Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

For all requests:

1. What is the patient’s weight? _____ (kg)
2. Is the patient currently treated with the requested agent? Yes No
 If yes, is the patient currently stable on the requested agent? **Please note, chart notes are required.** Yes No
3. Does this request include a loading dose? Yes No
 If yes, please specify: _____
4. Has the patient been treated with the requested agent within the past 90 days (starting on samples is not approvable)? Yes No
 If yes, is the patient at risk if therapy is changed? Yes No
 If yes, please explain risk: _____
5. Has the patient been tested for latent tuberculosis (TB) when required by the prescribing information for the requested agent? N/A Yes No
 If yes, were the results negative? Yes No
 If no, has the patient begun therapy for latent TB? Yes No

Please continue to the next page.

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For all requests continued:

6. Will the patient be using the requested agent in combination with another immunomodulatory agent (e.g., TNF inhibitors, JAK inhibitors, IL-4 inhibitors) [Abrilada (adalimumab-afzb), Actemra (tocilizumab), Adalimumab, Adbry (tralokinumab-ldrm), Amjevita (adalimumab-atto), Arcalyst (rilonacept), Avsola (infliximab-axxq), Avtozma (tocilizumab-anoh), Benlysta (belimumab), Bimzelx (bimekizumab-bkzx), Cibirgo (abrocitinib), Cimzia (certolizumab), Cinqair (reslizumab), Cosentyx (secukinumab), Cyltezo (adalimumab-adbm), Dupixent (dupilumab), Ebglyss (lebrikizumab-lbkz), Enbrel (etanercept), Entyvio (vedolizumab), Fasenra (benralizumab), Hadlima (adalimumab-bwwd), Hulio (adalimumab-fkjp), Humira (adalimumab), Hyrimoz (adalimumab-adaz), Idacio (adalimumab-aacf), Ilaris (canakinumab), Ilumya (tildrakizumab-asmn), Inflectra (infliximab-dyyb), Imuldosa (ustekinumab-srlf), Infliximab, Kevzara (sarilumab), Kineret (anakinra), Leqselvi (deuruxolitinib), Litfulo (ritlecitinib), Nemluvio (nemolizumab-ilto), Nucala (mepolizumab), Olumiant (baricitinib), Omlyclo (omalizumab-igec), Omvoh (mirikizumab-mrkz), Opzelura (ruxolitinib), Orenzia (abatacept), Otezla (apremilast), Otezla XR (apremilast extended-release), Otulfi (ustekinumab-aauz), Pyzchiva (ustekinumab-ttwe), Remicade (infliximab), Renflexis (infliximab-abda), Rhapsido (remibrutinib), Riabni (rituximab-arx), Rinvoq (upadacitinib), Rituxan (rituximab), Rituxan Hycela (rituximab/hyaluronidase human), Ruxience (rituximab-pvvr), Saphnelo (anifrolumab-fnia), Selarsdi (ustekinumab-aekn), Siliq (brodalumab), Simlandi (adalimumab-ryvk), Simponi (golimumab), Simponi ARIA (golimumab), Skyrizi (risankizumab-rzaa), Sotyktu (deucravacitinib), Spevigo (spesolimab-sbzo) subcutaneous injection, Starjemza (ustekinumab-hmny), Stelara (ustekinumab), Steqeyma (ustekinumab-stba), Taltz (ixekizumab), Tezspire (tezepelumab-ekko), Tofidence (tocilizumab-bavi), Tremfya (guselkumab), Truxima (rituximab-abbs), Tyenne (tocilizumab-aazg), Tyruko (natalizumab-sztn), Tysabri (natalizumab), Ustekinumab, Velsipity (etrasimod), Wezlana (ustekinumab-auub), Xeljanz (tofacitinib), Xeljanz XR (tofacitinib extended release), Xolair (omalizumab), Yesintek (ustekinumab-kfce), Yuflyma (adalimumab-aaty), Yusimry (adalimumab-aqvh), Zeposia (ozanimod), Zymfentra (infliximab-dyyb)]? Yes No
 If yes, does the prescribing information for the requested agent limit use with another immunomodulatory agent? Yes No
 If no, is there support for the use of combination therapy? **Please note, a submitted copy of clinical trials, phase III studies, or guidelines is required.** Yes No
7. Is the prescriber a specialist in the area of the patient's diagnosis (e.g., rheumatologist for JIA, PsA, RA; gastroenterologist for CD, UC; dermatologist for PS, AD, pulmonologist, radiologist, pathologist, rheumatologist for SSc-ILD; allergist, immunologist for AD) or has the prescriber consulted with a specialist in the area of the patient's diagnosis? Yes No
8. Is the patient's age within FDA labeling for the requested indication for the requested agent? Yes No
 If no, please provide support for using the requested agent for the patient's age for the requested indication: _____
9. Does the patient have any FDA labeled contraindication(s) to the requested agent? Yes No
 If yes, please specify FDA labeled contraindications: _____
10. Does the patient's medication history (excluding sample use) indicate use of a biologic immunomodulator agent or a systemic targeted synthetic small molecule drug (e.g., oral JAK inhibitor) that is FDA labeled or supported in compendia (AHFS, DrugDex 1, 2a, or 2b level of evidence, or NCCN 1, 2a, or 2b recommended use) for the treatment of the requested indication? Yes No
 If yes, please specify: _____
11. Does the requested quantity (dose) exceed the maximum FDA labeled dose for the requested indication? Yes No
 If yes, has the patient tried and had an inadequate response to at least a 3-month duration of therapy at the maximum FDA labeled dose for the requested indication? **Please note, medical records are required.** Yes No
12. Does the requested quantity (dose) exceed the maximum compendia (DrugDex with 1, 2a, or 2b level of evidence, AHFS, or NCCN compendium recommended use 1, 2a, or 2b) supported dose for the requested indication? Yes No
 If yes, is there support for therapy with a higher dose for the requested indication? **Please note, a submitted copy of clinical trials, phase III studies, or guidelines is required.** Yes No
13. Please list all reasons for selecting the requested agent for the indicated diagnosis, strength, dosing schedule, and quantity over alternatives (e.g., compendia support, journal articles, contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). **Please note, documentation may be required:** _____

Please continue to the next page.

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For all requests continued:

14. Has the patient been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat the cancer? Yes No
15. Has the patient been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat an associated condition related to stage four advanced metastatic cancer? **Please note, chart notes are required.** Yes No
16. If yes to either of the previous two questions, is the use of the requested agent consistent with best practices for the treatment of stage four advanced, metastatic cancer, or an associated condition; supported by peer-reviewed, evidence-based literature; and approved by the United States Food and Drug Administration?..... Yes No
- **Please submit chart notes to support the answers to the following questions:**
17. Has the patient tried and had an inadequate response to any immunomodulatory agents (see question 6 for list of agents) for the requested indication after at least a 3-month duration of therapy per agent? Yes No
18. Were any immunomodulatory agents discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
19. Does the patient have an intolerance (defined as an intolerance to the drug or its excipients, not to the route of administration) or hypersensitivity to any immunomodulatory agents?..... Yes No
20. Does the patient have an FDA labeled contraindication to any immunomodulatory agents? Yes No
21. Are any immunomodulatory agents expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm? Yes No
22. Are any immunomodulatory agents not in the best interest of the patient based on medical necessity? Yes No
23. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as any immunomodulatory agents and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
24. Are any immunomodulatory agents not clinically appropriate for the patient? Yes No

If yes, please provide supporting information: _____

Please list ALL previously tried agents for the requested indication: _____

For ankylosing spondylitis (AS) requests:

25. Has the patient tried and had an inadequate response to TWO different nonsteroidal anti-inflammatory drugs (NSAIDs) used in the treatment of AS after at least a 4-week TOTAL duration of therapy?..... Yes No
- If no, has the patient tried and had an inadequate response to ONE NSAID used in the treatment of AS after at least a 4-week duration of therapy and an intolerance or hypersensitivity to ONE additional NSAID used in the treatment of AS..... Yes No
- If yes, please specify agent tried and explain intolerance/hypersensitivity to another agent: _____
- If no, does the patient have an intolerance or hypersensitivity to TWO different NSAIDs used in the treatment of AS? Yes No
- If yes, please explain intolerance/hypersensitivity: _____
- If no, does the patient have an FDA labeled contraindication to ALL NSAIDs used in the treatment of AS? Yes No
- If yes, please specify FDA labeled contraindication: _____
26. Is the requested agent Cosentyx? Yes No
- If yes, is 300mg every 4 weeks being requested as maintenance dosing? Yes No
- If yes, has the patient tried and had an inadequate response to Cosentyx 150mg every 4 weeks after at least a 3-month duration of therapy? Yes No

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For enthesitis related arthritis (ERA) requests:

27. Has the patient tried and had an inadequate response to TWO different NSAIDs used in the treatment of ERA after at least a 4-week TOTAL duration of therapy? Yes No
- If no, has the patient tried and had an inadequate response to ONE NSAID used in the treatment of ERA after at least a 4-week duration of therapy and an intolerance or hypersensitivity to ONE additional NSAID used in the treatment of ERA? Yes No
- If yes, please specify agent tried and explain intolerance/hypersensitivity to another agent: _____
- _____
- If no, does the patient have an intolerance or hypersensitivity to TWO different NSAIDs used in the treatment of ERA? Yes No
- If yes, please explain intolerance/hypersensitivity: _____
- _____
- If no, does the patient have an FDA labeled contraindication to ALL NSAIDs used in the treatment of ERA? Yes No
- If yes, please specify FDA labeled contraindication: _____
- _____

For atopic dermatitis (AD) requests:

28. Does the patient have at least 10% body surface area involvement? Yes No
- If no, does the patient have involvement of body sites that are difficult to treat with prolonged topical corticosteroid therapy (e.g., hands, feet, face, neck, scalp, genitals/groin, skin folds)? Yes No
- If no, does the patient have an Eczema Area and Severity Index (EASI) score of greater than or equal to 16? Yes No
- If no, does the patient have an investigator Global Assessment (IGA) score of greater than or equal to 3? Yes No
29. Has the patient tried and had an inadequate response to one at least mid-potency topical steroid used in the treatment of AD after at least a 4-week duration of therapy? Yes No
- If no, does the patient have an intolerance or hypersensitivity to one at least mid-potency topical steroid used in the treatment of AD? Yes No
- If yes, please explain intolerance/hypersensitivity: _____
- _____
- If no, does the patient have an FDA labeled contraindication to ALL mid-, high-, and super-potency topical steroids used in the treatment of AD? Yes No
- If yes, please specify FDA labeled contraindication: _____
- _____
30. Has the patient tried and had an inadequate response to a topical calcineurin inhibitor (e.g., Elidel/pimecrolimus, Protopic/tacrolimus) used in the treatment of AD after at least a 6-week duration of therapy? Yes No
- If no, does the patient have an intolerance or hypersensitivity to a topical calcineurin inhibitor used in the treatment of AD? Yes No
- If yes, please explain intolerance/hypersensitivity: _____
- _____
- If no, does the patient have an FDA labeled contraindication to ALL topical calcineurin inhibitors used in the treatment of AD? Yes No
- If yes, please specify FDA labeled contraindication: _____
- _____
31. Is the patient currently treated with topical emollients and practicing good skin care? Yes No
- If yes, will the patient continue the use of topical emollients and good skin care practices in combination with the requested agent? Yes No

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For Crohn's disease (CD) requests:

32. Does the patient have severely active Crohn's disease? Yes No
33. Has the patient tried and had an inadequate response to ONE conventional agent (i.e., 6-mercaptopurine, azathioprine, corticosteroids [e.g., prednisone, budesonide EC capsule], methotrexate) used in the treatment of CD after at least a 3-month duration of therapy? Yes No
- If no, please answer the following questions:**
- Was ONE conventional agent used in the treatment of CD discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
 - Does the patient have an intolerance or hypersensitivity to ONE conventional agent used in the treatment of CD? Yes No
If yes, please explain intolerance/hypersensitivity: _____
 - Does the patient have an FDA labeled contraindication to ALL conventional agents used in the treatment of CD? Yes No
If yes, please specify FDA labeled contraindication: _____
 - Is ONE conventional agent used in the treatment of CD expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm? Yes No
 - Is ONE conventional agent used in the treatment of CD not in the best interest of the patient based on medical necessity? Yes No
 - Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as ONE conventional agent used in the treatment of CD and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
34. Is the requested agent Entyvio? Yes No
If yes, has the patient received at least 2 doses of Entyvio IV therapy? Yes No
If no, is the patient new to therapy and will receive at least 2 doses of Entyvio IV therapy? Yes No
If no, is the patient currently established on subcutaneous therapy with the active drug for the requested indication and IV induction therapy is no longer clinically appropriate? Yes No
35. Is the requested agent Omvoh? Yes No
If yes, has the patient received Omvoh IV for induction therapy? Yes No
If no, is the patient new to therapy and will receive Omvoh IV for induction therapy? Yes No
If no, is the patient currently established on subcutaneous therapy with the active drug for the requested indication and IV induction therapy is no longer clinically appropriate? Yes No
36. Is the requested agent Skyrizi? Yes No
If yes, has the patient received Skyrizi IV for induction therapy? Yes No
If no, is the patient new to therapy and will receive Skyrizi IV for induction therapy? Yes No
If no, is the patient currently established on subcutaneous therapy with the active drug for the requested indication and IV induction therapy is no longer clinically appropriate? Yes No
37. Is the requested agent an ustekinumab product? Yes No
If yes, has the patient received an ustekinumab IV product for induction therapy? Yes No
If no, is the patient new to therapy and will receive an ustekinumab IV product for induction therapy? Yes No
If no, is the patient currently established on subcutaneous therapy with the active drug for the requested indication and IV induction therapy is no longer clinically appropriate? Yes No
38. Is the requested agent Zymfentra? Yes No
If yes, has the patient received an infliximab IV product for induction therapy? Yes No
If no, is the patient new to therapy and will receive an infliximab IV product for induction therapy? Yes No
If no, is the patient currently established on subcutaneous therapy with the active drug for the requested indication and IV induction therapy is no longer clinically appropriate? Yes No

Please continue to the next page.

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For systemic sclerosis associated interstitial lung disease (SSc-ILD) requests:

39. Has the patient's diagnosis been confirmed on high-resolution computed tomography (HRCT) or chest radiography scans? Yes No

For hidradenitis suppurativa (HS) requests:

40. Has the patient tried and had an inadequate response to ONE conventional agent [i.e., oral tetracyclines (doxycycline, minocycline, tetracycline); oral contraceptives (females only); metformin (females only); finasteride (females only); spironolactone (females only); intralesional corticosteroids (triamcinolone); clindamycin in combination with rifampin, combination of rifampin, moxifloxacin, and metronidazole; cyclosporine; oral retinoids] used in the treatment of HS after at least a 3-month duration of therapy? Yes No

If no, does the patient have an intolerance or hypersensitivity to ONE conventional agent used in the treatment of HS? Yes No

If yes, please explain intolerance/hypersensitivity: _____

If no, does the patient have an FDA labeled contraindication to ALL conventional agents used in the treatment of HS? Yes No

If yes, please specify FDA labeled contraindication: _____

41. Is the requested agent Cosentyx? Yes No

If yes, is 300mg every 4 weeks being requested as maintenance dosing? Yes No

If no, is 300mg every 2 weeks being requested as maintenance dosing? Yes No

If yes, has the patient tried and had an inadequate response to Cosentyx 300mg every 4 weeks after at least a 3-month duration of therapy? Yes No

For juvenile psoriatic arthritis (JPsA) requests:

42. Has the patient tried and had an inadequate response to ONE conventional agent (i.e., methotrexate, leflunomide, sulfasalazine) used in the treatment of JPsA after at least a 3-month duration of therapy? Yes No

If no, does the patient have an intolerance or hypersensitivity to ONE conventional agent used in the treatment of JPsA? Yes No

If yes, please explain intolerance/hypersensitivity: _____

If no, does the patient have an FDA labeled contraindication to methotrexate? Yes No

If yes, please specify FDA labeled contraindication: _____

43. Does the patient have severe active JPsA (e.g., erosive disease, elevated markers of inflammation [e.g., ESR, CRP] attributable to JPsA, long-term damage that interferes with function [i.e., joint deformities, vision loss], rapidly progressive? Yes No

44. Does the patient have concomitant severe psoriasis (PS) (e.g., greater than 10% body surface area involvement, occurring on select locations [i.e., hands, feet, scalp, face, or genitals], intractable pruritus, serious emotional consequences)? Yes No

For non-radiographic axial spondyloarthritis (nr-axSpA) requests:

45. Has the patient tried and had an inadequate response to TWO different NSAIDs used in the treatment of nr-axSpA after at least a 4-week TOTAL duration of therapy? Yes No

If no, has the patient tried and had an inadequate response to ONE NSAID used in the treatment of nr-axSpA after at least a 4-week duration of therapy and an intolerance or hypersensitivity to ONE additional NSAID used in the treatment of nr-axSpA? Yes No

If yes, please specify agent tried and explain intolerance/hypersensitivity to another agent: _____

If no, does the patient have an intolerance or hypersensitivity to TWO different NSAIDs used in the treatment of nr-axSpA? Yes No

If yes, please explain intolerance/hypersensitivity: _____

If no, does the patient have an FDA labeled contraindication to ALL NSAIDs used in the treatment of nr-axSpA? Yes No

If yes, please specify FDA labeled contraindication: _____

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For plaque psoriasis (PS) requests:

46. Has the patient tried and had an inadequate response to ONE conventional agent (i.e., acitretin, calcipotriene, calcitriol, coal tar, cyclosporine, methotrexate, pimecrolimus, PUVA (phototherapy), tacrolimus, tazarotene, topical corticosteroids) used in the treatment of PS after at least a 3-month duration of therapy? Yes No
 If no, does the patient have an intolerance or hypersensitivity to ONE conventional agent used in the treatment of PS? Yes No
 If yes, please explain intolerance/hypersensitivity: _____

 If no, does the patient have an FDA labeled contraindication to ALL conventional agents used in the treatment of PS? Yes No
 If yes, please specify FDA labeled contraindication: _____

47. Does the patient have severe active PS [e.g., greater than 10% body surface area involvement, occurring on select locations (i.e., hands, feet, scalp, face, or genitals), intractable pruritus, serious emotional consequences]? Yes No
 48. Does the patient have concomitant severe psoriatic arthritis (PsA) [e.g., erosive disease, elevated markers of inflammation (e.g., ESR, CRP) attributable to PsA, long-term damage that interferes with function (i.e., joint deformities, vision loss), rapidly progressive]? Yes No

For polyarticular juvenile idiopathic arthritis (PJIA) requests:

49. Does the patient have a diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis (PJIA)? Yes No
 50. Has the patient tried and had an inadequate response to ONE conventional agent (i.e., methotrexate, leflunomide) used in the treatment of PJIA after at least a 3-month duration of therapy? Yes No
 If no, does the patient have an intolerance or hypersensitivity to ONE conventional agent used in the treatment of PJIA? Yes No
 If yes, please explain intolerance/hypersensitivity: _____

 If no, does the patient have an FDA labeled contraindication to ALL conventional agents used in the treatment of PJIA? Yes No
 If yes, please specify FDA labeled contraindication: _____

 51. Is the requested agent Xeljanz oral solution? Yes No
 If yes, please provide information stating why the patient cannot take Xeljanz 5 mg tablets: _____

For psoriatic arthritis (PsA) requests:

52. Has the patient tried and had an inadequate response to ONE conventional agent (i.e., cyclosporine, leflunomide, methotrexate, sulfasalazine) used in the treatment of PsA after at least a 3-month duration of therapy? Yes No
 If no, does the patient have an intolerance or hypersensitivity to ONE conventional agent used in the treatment of PsA? Yes No
 If yes, please explain intolerance/hypersensitivity: _____

 If no, does the patient have an FDA labeled contraindication to ALL conventional agents used in the treatment of PsA? Yes No
 If yes, please specify FDA labeled contraindication: _____

 53. Does the patient have severe active PsA [e.g., erosive disease, elevated markers of inflammation (e.g., ESR, CRP) attributable to PsA, long-term damage that interferes with function (i.e., joint deformities, vision loss), rapidly progressive]? Yes No
 54. Does the patient have concomitant severe psoriasis (PS) [e.g., greater than 10% body surface area involvement, occurring on select locations (i.e., hands, feet, scalp, face, or genitals), intractable pruritus, serious emotional consequences]? Yes No
 55. Is the requested agent Cosentyx? Yes No
 If yes, is 300mg every 4 weeks being requested as maintenance dosing? Yes No
 If yes, has the patient tried and had an inadequate response to Cosentyx 150mg every 4 weeks after at least a 3-month duration of therapy? Yes No
 56. Is the requested agent Xeljanz oral solution? Yes No
 If yes, please provide information stating why the patient cannot take Xeljanz 5 mg tablets: _____

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For ulcerative colitis (UC) requests:

57. Does the patient have severely active ulcerative colitis? Yes No
58. Has the patient tried and had an inadequate response to ONE conventional agent (i.e., 6-mercaptopurine, azathioprine, balsalazide, corticosteroids, cyclosporine, mesalamine, sulfasalazine) used in the treatment of UC after at least a 3-month duration of therapy? Yes No
- If no, please answer the following questions:**
- Was ONE conventional agent used in the treatment of UC discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
 - Does the patient have an intolerance or hypersensitivity to ONE conventional agent used in the treatment of UC? Yes No
If yes, please explain intolerance/hypersensitivity: _____
 - Does the patient have an FDA labeled contraindication to ALL conventional agents used in the treatment of UC? Yes No
If yes, please specify FDA labeled contraindication: _____
 - Is ONE conventional agent used in the treatment of UC expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm? Yes No
 - Is ONE conventional agent used in the treatment of UC not in the best interest of the patient based on medical necessity? Yes No
 - Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as ONE conventional agent used in the treatment of UC and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
59. Is the requested agent Entyvio? Yes No
If yes, has the patient received at least 2 doses of Entyvio IV therapy? Yes No
If no, is the patient new to therapy and will receive at least 2 doses of Entyvio IV therapy? Yes No
If no, is the patient currently established on subcutaneous therapy with the active drug for the requested indication and IV induction therapy is no longer clinically appropriate? Yes No
60. Is the requested agent Omvoh? Yes No
If yes, has the patient received Omvoh IV for induction therapy? Yes No
If no, is the patient new to therapy and will receive Omvoh IV for induction therapy? Yes No
If no, is the patient currently established on subcutaneous therapy with the active drug for the requested indication and IV induction therapy is no longer clinically appropriate? Yes No
61. Is the requested agent Skyrizi? Yes No
If yes, has the patient received Skyrizi IV for induction therapy? Yes No
If no, is the patient new to therapy and will receive Skyrizi IV for induction therapy? Yes No
If no, is the patient currently established on subcutaneous therapy with the active drug for the requested indication and IV induction therapy is no longer clinically appropriate? Yes No
62. Is the requested agent an ustekinumab product? Yes No
If yes, has the patient received an ustekinumab IV product for induction therapy? Yes No
If no, is the patient new to therapy and will receive an ustekinumab IV product for induction therapy? Yes No
If no, is the patient currently established on subcutaneous therapy with the active drug for the requested indication and IV induction therapy is no longer clinically appropriate? Yes No
63. Is the requested agent Zymfentra? Yes No
If yes, has the patient received an infliximab IV product for induction therapy? Yes No
If no, is the patient new to therapy and will receive an infliximab IV product for induction therapy? Yes No
If no, is the patient currently established on subcutaneous therapy with the active drug for the requested indication and IV induction therapy is no longer clinically appropriate? Yes No

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For rheumatoid arthritis (RA) requests:

64. Has the patient tried and had an inadequate response to maximally tolerated methotrexate (e.g., titrated to 25 mg weekly) after at least a 3-month duration of therapy? Yes No
65. Has the patient tried and had an inadequate response to ONE conventional agent (i.e., hydroxychloroquine, leflunomide, sulfasalazine) used in the treatment of RA after at least a 3-month duration of therapy? Yes No
66. If no to both of the previous two questions, does the patient have an intolerance or hypersensitivity to ONE of the following conventional agents (i.e., methotrexate, hydroxychloroquine, leflunomide, sulfasalazine) used in the treatment of RA? Yes No
 If yes, please explain intolerance/hypersensitivity: _____
- If no, does the patient have an FDA labeled contraindication to ALL of the following conventional agents (i.e., methotrexate, hydroxychloroquine, leflunomide, and sulfasalazine) used in the treatment of RA? Yes No
 If yes, please specify FDA labeled contraindication: _____
67. Is the requested agent Simponi? Yes No
 If yes, will the patient be taking the requested agent in combination with methotrexate? Yes No
 If no, does the patient have an intolerance, FDA labeled contraindication, or hypersensitivity to methotrexate? Yes No
 If yes, please explain: _____

For uveitis requests:

68. Does the patient have a diagnosis of non-infectious intermediate uveitis, posterior uveitis, or panuveitis? Yes No
69. Has the patient tried and had an inadequate response to ONE oral corticosteroid used in the treatment of non-infectious intermediate uveitis, posterior uveitis, or panuveitis after at least a 2-week duration of therapy? . Yes No
70. Has the patient tried and had an inadequate response to ONE periocular or intravitreal corticosteroid injection used in the treatment of non-infectious intermediate uveitis, posterior uveitis, or panuveitis? Yes No
71. If no to both of the previous two questions, does the patient have an intolerance or hypersensitivity to ONE oral corticosteroid OR periocular or intravitreal corticosteroid injection used in the treatment of non-infectious intermediate uveitis, posterior uveitis, or panuveitis? Yes No
 If yes, please explain intolerance/hypersensitivity: _____
- If no, does the patient have an FDA labeled contraindication to ALL oral corticosteroids and periocular/intravitreal corticosteroids used in the treatment of non-infectious intermediate uveitis, posterior uveitis, or panuveitis? Yes No
 If yes, please specify FDA labeled contraindication: _____
72. Does the patient have severe, active, sight-threatening disease? Yes No
 If no, has the patient tried and had an inadequate response to ONE conventional systemic agent (i.e., azathioprine, mycophenolate, methotrexate, cyclosporine, tacrolimus) used in the treatment of non-infectious intermediate uveitis, posterior uveitis, or panuveitis after at least a 3-month duration of therapy?... Yes No
 If no, does the patient have an intolerance or hypersensitivity to ONE conventional systemic agent used in the treatment of non-infectious intermediate uveitis, posterior uveitis, or panuveitis? Yes No
 If yes, please explain intolerance/hypersensitivity: _____
- If no, does the patient have an FDA labeled contraindication to ALL conventional systemic agents used in the treatment of non-infectious intermediate uveitis, posterior uveitis, or panuveitis? Yes No
 If yes, please specify FDA labeled contraindication: _____

For alopecia areata (AA) requests:

73. Does the patient have at least 50% scalp hair loss that has lasted 6 months or more? Yes No

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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For polymyalgia rheumatica (PMR) requests:

74. Has the patient tried and had an inadequate response to systemic corticosteroids at a dose equivalent to at least 7.5 mg/day of prednisone used in the treatment of PMR after at least an 8-week duration of therapy? Yes No
 If no, is the patient currently treated with systemic corticosteroids at a dose equivalent to at least 7.5 mg/day of prednisone and cannot tolerate a corticosteroid taper?..... Yes No

For giant cell arteritis (GCA) requests:

75. Has the patient tried and had an inadequate response to ONE systemic corticosteroid (e.g., prednisone, methylprednisolone) used in the treatment of GCA after at least a 7-day duration of therapy?..... Yes No
 If no, does the patient have an intolerance or hypersensitivity to ONE systemic corticosteroid used in the treatment of GCA? Yes No
 If yes, please explain intolerance/hypersensitivity: _____

 If no, does the patient have an FDA labeled contraindication to ALL systemic corticosteroids used in the treatment of GCA? Yes No
 If yes, please specify FDA labeled contraindication: _____

For all renewal requests:

76. Has the patient had clinical benefit with the requested agent? Yes No

For atopic dermatitis (AD) renewal requests:

77. Will the patient continue standard maintenance therapies (e.g., topical emollients, good skin care practices) in combination with the requested agent? Yes No

For polymyalgia rheumatica (PMR) renewal requests:

78. Is the requested agent Kevzara?..... Yes No
 If yes, does the patient have any of the following: 1) neutropenia (ANC less than 1,000 per mm³ at the end of the dosing interval), 2) thrombocytopenia (platelet count is less than 100,000 per mm³), or 3) AST or ALT elevations 3 times the upper limit of normal? Yes No

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TOLL FREE

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