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:

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

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
3. Does this request include a loading dose? ☐ Yes ☐ No
   If yes, please specify: _____
4. Has the patient been treated with the requested agent (starting on samples is not approvable) within the past 90 days? ☐ Yes ☐ No
   If yes, is the patient at risk if therapy is changed? ☐ Yes ☐ No
   If yes, please explain: _____
5. Has the patient been tested for latent tuberculosis (TB) when required by the prescribing information for the requested agent? ☐ NA ☐ 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.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):

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), Adbry (tralokinumab-ldrm), Amjevita (adalimumab-atto), Arcalyst (rilonacept), Avsola (infliximab-axxq), Benlysta (belimumab), Bimzelx (bimekizumab-bkzx), Cibinqo (abrocitinib), Cimzia (certolizumab), Cinqair (reslizumab), Cosentyx (secukinumab), Cyltezo (adalimumab-adbm), Dupixent (dupilumab), 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), Infliximab, Kevzara (sarilumab), Kineret (anakinra), Litfulo (ritlecitinib), Nucala (mepolizumab), Olumiant (baricitinib), Omvoh (mirikizumab-mrkz), Opzelura (ruxolitinib), Orencia (abatacept), Otezla (apremilast), Remicade (infliximab), Renflexis (infliximab-abda), Riabni (rituximab-arrx), Rinvoq (upadacitinib), Rituxan (rituximab), Rituxan Hycela (rituximab/hyaluronidase human), Ruxience (rituximab-pvvr), Siliq (brodalumab), Simponi (golimumab), Simponi ARIA (golimumab), Skyrizi (risankizumab-rzaa), Sotyktu (deucravacitinib), Stelara (ustekinumab), Taltz (ixekizumab), Tezspire (tezepelumab-ekko), Tremfya (guselkumab), Truxima (rituximab-abbs), Tysabri (natalizumab), Velsipity (etrasimod), Wezlana (ustekinumab-auub), Xeljanz (tofacitinib), Xeljanz XR (tofacitinib extended release), Xolair (omalizumab), 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 information in support of combination therapy? **Please submit copy of information such as clinical trials, phase II studies, guidelines.** ☐ 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 rationale in support of 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 indicate use of another biologic immunomodulator agent that is FDA labeled or supported in compendia (DrugDex with 1 or 2a level of evidence, AHFS, or NCCN compendium recommended use 1 or 2a) for the requested indication? ☐ Yes ☐ No
    - If yes, please specify: _____
11. Is the requested quantity (dose) greater than the maximum FDA labeled dose? ☐ Yes ☐ No
    - If yes, has the patient tried and had an inadequate response to at least a 3-month trial of the maximum FDA labeled dose? **Please note, medical records required.** ☐ Yes ☐ No
12. Is the requested quantity (dose) greater than the maximum compendia (DrugDex with 1 or 2a level of evidence, AHFS, or NCCN compendium recommended use 1 or 2a) supported dose (for the requested indication? ☐ Yes ☐ No
    - If yes, is there information in support of therapy with a higher dose for the requested indication? ☐ Yes ☐ No
      - If yes, **please submit a copy of information (e.g., clinical trials, phase III studies, guidelines required).**
13. Can the requested quantity (dose) be achieved with a lower quantity of a higher strength and/or package size? ☐ Yes ☐ No
    - If no, please explain: _____
14. Is Cosentyx 300 mg every 4 weeks requested as maintenance dosing? ☐ Yes ☐ No
    - If yes, does the patient have a diagnosis of moderate to severe plaque psoriasis with or without coexistent active psoriatic arthritis? ☐ Yes ☐ No
    - If yes, does the patient have a diagnosis of active psoriatic arthritis or active ankylosing spondylitis AND has tried and had an inadequate response to Cosentyx 150 mg every 4 weeks for at least 3 months? ☐ Yes ☐ No
15. Is Stelara 90 mg requested? ☐ Yes ☐ No
    - If yes, does the patient have a diagnosis of psoriasis AND weighs >100kg? ☐ Yes ☐ No
    - If yes, does the patient have a dual diagnosis of psoriasis AND psoriatic arthritis AND the patient is >100kg? ☐ Yes ☐ No
    - If yes, does the patient have a diagnosis of Crohn's disease or Ulcerative Colitis? ☐ Yes ☐ No

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):

For all requests continued:

16. Has the patient been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat the cancer? ☐ Yes ☐ No
17. 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
18. 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:

19. Has the patient tried and had an inadequate response to any immunomodulatory agents (see question 6 for list of agents) for the requested indication for at least 3 months? ☐ Yes ☐ No
20. Were any immunomodulatory agents discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? ☐ Yes ☐ No
21. 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
22. Does the patient have an FDA labeled contraindication to any immunomodulatory agents? ☐ Yes ☐ No
23. 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
24. Are any immunomodulatory agents not in the best interest of the patient based on medical necessity? ☐ Yes ☐ No
25. 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
26. 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:

27. Has the patient tried and had an inadequate response to 2 different NSAIDs used in the treatment of AS for at least a 4-week total trial? ☐ Yes ☐ No
    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: _____
    _____

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 at least a mid- potency topical steroid used in the treatment of AD for a minimum of 4 weeks? ☐ Yes ☐ No
    If no, does the patient have an intolerance or hypersensitivity to at least a 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: _____
    _____

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):

For atopic dermatitis (AD) requests continued:

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 for a minimum of 6 weeks? ☐ Yes ☐ No
    If no, does the patient have an intolerance or hypersensitivity to a topical calcineurin inhibitor? ☐ Yes ☐ No
    If yes, please explain intolerance/hypersensitivity: _____
    If no, does the patient have an FDA labeled contraindication to ALL topical calcineurin inhibitors? ☐ Yes ☐ No
    If yes, please specify FDA labeled contraindication: _____
31. Has the patient tried and had an inadequate response to a systemic immunosuppressant, including a biologic, used in the treatment of AD for a minimum of 3 months? ☐ Yes ☐ No
    If no, does the patient have an intolerance or hypersensitivity to therapy with systemic immunosuppressants, including a biologic, 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 systemic immunosuppressants, including biologics, used in the treatment of AD? ☐ Yes ☐ No
    If yes, please specify FDA labeled contraindication: _____
32. Has the prescriber documented the patient's baseline pruritus and other symptom severity (e.g., erythema, edema, xerosis, erosions/excoriations, oozing and crusting, and/or lichenification)? ☐ Yes ☐ No
33. 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

For Crohn's disease (CD) requests:

***Please note: The prerequisite biologic immunomodulators for CD are Amjevita (one of 10mg/0.2mL, 20mg/0.4mL, 40mg/0.8mL), Cyltezo, Hadlima, Humira, Rinvoq, Skyrizi, and Stelara. For Cimzia, a three-month trial and failure of Amjevita (one of 10mg/0.2mL, 20mg/0.4mL, 40mg/0.8mL), Cyltezo, Hadlima, or Humira is required.**

34. 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 for at least 3 months? ☐ Yes ☐ No
    If no, does the patient have an intolerance or hypersensitivity to ONE of the conventional agents used in the treatment of CD? ☐ Yes ☐ No
    If yes, please explain intolerance/hypersensitivity: _____
    If no, does the patient have an FDA labeled contraindication to ALL of the conventional agents used in the treatment of CD? ☐ Yes ☐ No
    If yes, please specify FDA labeled contraindication: _____
35. Is the requested agent Skyrizi? ☐ Yes ☐ No
    If yes, has the patient received Skyrizi IV for induction therapy? ☐ Yes ☐ No
36. Is the requested agent Stelara? ☐ Yes ☐ No
    If yes, has the patient received Stelara IV for induction therapy? ☐ Yes ☐ No
37. Is the requested agent Entyvio? ☐ Yes ☐ No
    If yes, has the patient received at least 2 doses of Entyvio intravenous therapy? ☐ Yes ☐ No
38. Is the requested agent Omvoh? ☐ Yes ☐ No
    If yes, has the patient received Omvoh IV for induction therapy? ☐ Yes ☐ No

For enthesitis related arthritis (ERA) requests:

39. Has the patient tried and had an inadequate response to two different NSAIDs used in the treatment of ERA for at least a 4-week total trial? ☐ Yes ☐ No
    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: _____

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):

For giant cell arteritis (GCA) requests:

40. Has the patient tried and had an inadequate response to systemic corticosteroids (e.g., prednisone, methylprednisolone) used in the treatment of GCA for at least 7-10 days? ☐ Yes ☐ No
    If no, does the patient have an intolerance or hypersensitivity to systemic corticosteroids 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? ☐ Yes ☐ No
    If yes, please specify FDA labeled contraindication: _____
    _____

For hidradenitis suppurativa (HS) requests:

41. Does the patient have a diagnosis of moderate to severe hidradenitis suppurative (HS)? ☐ Yes ☐ No
42. 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 for at least 3 months? ☐ 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: _____
    _____

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

43. Has the patient tried and had an inadequate response to two different NSAIDs used in the treatment of nr-axSpA for at least a 4-week total trial? ☐ Yes ☐ No
    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: _____
    _____

For psoriasis (PS) requests:

44. Has the patient tried and had an inadequate response to ONE conventional agent (i.e., acitretin, anthralin, calcipotriene, calcitriol, coal tar products, cyclosporine, methotrexate, pimecrolimus, PUVA (phototherapy), tacrolimus, tazarotene, topical corticosteroids) used in the treatment of PS for at least 3 months? ☐ 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: _____
    _____
45. 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
46. 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), rapidly progressive? ☐ Yes ☐ No

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):

For polyarticular juvenile idiopathic arthritis (PJIA) requests:

47. Does the patient have a diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis (PJIA)? ☐ Yes ☐ No
48. Has the patient tried and had an inadequate response to ONE conventional agent (i.e., methotrexate, leflunomide) used in the treatment of PJIA for at least 3 months? ☐ Yes ☐ No
    If no, does the patient have an intolerance or hypersensitivity to ONE of the conventional agents 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 of the conventional agents used in the treatment of PJIA? ☐ Yes ☐ No
    If yes, please specify FDA labeled contraindication: _____
49. 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:

50. 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 for at least 3-months? ☐ Yes ☐ No
    If no, does the patient have an intolerance or hypersensitivity to ONE of the conventional agents 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 of the conventional agents used in the treatment of PsA? ☐ Yes ☐ No
    If yes, please specify FDA labeled contraindication: _____
51. 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), rapidly progressive)? ☐ Yes ☐ No
52. 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 rheumatoid arthritis (RA) requests:

53. Has the patient tried and had an inadequate response to maximally tolerated methotrexate (e.g., titrated to 25 mg weekly) for at least 3 months? ☐ Yes ☐ No
54. Has the patient tried and had an inadequate response to another conventional agent (i.e., hydroxychloroquine, leflunomide, sulfasalazine) used in the treatment of RA for at least 3 months? ☐ Yes ☐ No
55. 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., maximally tolerated 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: _____
56. 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: _____

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):

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

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

For ulcerative colitis (UC) requests:

***Please note: The prerequisite biologic immunomodulators for UC are Amjevita (one of 10mg/0.2mL, 20mg/0.4mL, 40mg/0.8mL), Cyltezo, Hadlima, Humira, Rinvoq, and Stelara. For Simponi, a three-month trial and failure of are Amjevita (one of 10mg/0.2mL, 20mg/0.4mL, 40mg/0.8mL), Cyltezo, Hadlima, or Humira is required.**

58. Does the patient have severely active ulcerative colitis? ☐ Yes ☐ No
59. 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 for at least 3 months? ☐ Yes ☐ No
    If no, does the patient have an intolerance or hypersensitivity to ONE of the conventional agents used in the treatment of UC? ☐ Yes ☐ No
    If yes, please explain intolerance/hypersensitivity:_____
    _____
    If no, does the patient have an FDA labeled contraindication to ALL of the conventional agents used in the treatment of UC? ☐ Yes ☐ No
    If yes, please specify FDA labeled contraindication: _____
    _____

For uveitis requests:

60. Does the patient have a diagnosis of non-infectious intermediate uveitis, posterior uveitis, or panuveitis? ☐ Yes ☐ No
61. Has the patient tried and had an inadequate response to oral corticosteroids used in the treatment of non-infectious intermediate uveitis, posterior uveitis, or panuveitis for a minimum of 2 weeks? ☐ Yes ☐ No
62. Has the patient tried and had an inadequate response to periocular or intravitreal corticosteroid injections in the treatment of non-infectious intermediate uveitis, posterior uveitis, or panuveitis? ☐ Yes ☐ No
    If no, does the patient have an intolerance or hypersensitivity to oral corticosteroids OR periocular or intravitreal corticosteroid injections 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 BOTH oral corticosteroids and periocular/intravitreal corticosteroids? ☐ Yes ☐ No
    If yes, please specify FDA labeled contraindication: _____
    _____
63. 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 for at least 3 months? ☐ 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:

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

For polymyalgia rheumatica (PMR) requests:

65. 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 for a minimum of 8 weeks? ☐ 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

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):

For all renewal requests:

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

For atopic dermatitis (AD) renewal requests:

67. Did the patient have a diagnosis of moderate to severe atopic dermatitis? ☐ Yes ☐ No
68. Has the patient had a reduction or stabilization from baseline (prior to therapy with the requested agent) of ONE of the following: 1) affected body surface area, 2) flares, 3) pruritus, erythema, edema, xerosis, erosions/excoriations, oozing and crusting, and/or lichenification, 4) a decrease in the Eczema Area and Severity Index (EASI) score, or 5) a decrease in the Investigator Global Assessment (IGA) score? ☐ Yes ☐ No
69. 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:

69. 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 mm^3 at the end of the dosing interval), 2) thrombocytopenia (platelet count is less than 100,000 per mm^3), or 3) AST or ALT elevations 3 times the upper limit of normal? ☐ Yes ☐ No

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