

# HCPA 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](http://www.myprime.com). Start saving time today by filling out this form electronically. Visit [covermyeds.com](http://covermyeds.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 #:	

**RENDERING/SERVICING PRESCRIBER INFORMATION (IF APPLICABLE)**

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 (ICD code plus description):	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

**For all requests:**

- What is the patient's weight? \_\_\_\_\_ (kg)
- Is the patient currently being 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
- Does this request include a loading dose? .....  Yes  No  
 If yes, please specify: \_\_\_\_\_
- 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 specify risk: \_\_\_\_\_
- Does the patient have any FDA labeled contraindications to the requested agent? .....  Yes  No  
 If yes, please specify FDA labeled contraindications: \_\_\_\_\_
- Has the patient been tested for latent tuberculosis (TB)? .....  N/A  Yes  No  
 If yes, were the results negative? .....  Yes  No  
 If no, has the patient begun therapy for latent TB? .....  Yes  No
- Is the prescriber a specialist in the area of the patient's diagnosis (e.g., rheumatologist for PsA, RA; gastroenterologist for CD, UC; dermatologist for PS; oncologist for CRS), or has the prescriber consulted with a specialist in the area of the patient's diagnosis? .....  Yes  No

**Please continue to the next page.**

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7. 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), Fasenna (benralizumab), Hadlima (adalimumab-bwwd), Hulio (adalimumab-fkjp), Humira (adalimumab), Hyrimoz (adalimumab-adaz), Idacio (adalimumab-aacf), Ilaris (canakinumab), Ilumya (tildrakizumab-asmn), Imuldosa (ustekinumab-srlf), Inflectra (infliximab-dyyb), Infliximab, Kevzara (sarilumab), Kineret (anakinra), Litfulo (ritlectinib), Nucala (mepolizumab), Olumiant (baricitinib), Omyclo (omalizumab-igec), (Omvoh (mirikizumab-mrkz), Opzelura (ruxolitinib), Orenzia (abatacept), Otezla (apremilast), Otezla XR (apremilast extended release), Otulfi (Ustekinumab-aauz), Remicade (infliximab), Renflexis (infliximab-abda), Rhapsido (remibrutinib), Riabni (rituximab-arrr), Rinvoq (upadacitinib), Rituxan (rituximab), Rituxan Hycela (rituximab/hyaluronidase human), Ruxience (rituximab-pvvr), 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
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'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 (i.e., AHFS, DrugDex with 1, 2a, or 2b level of evidence, or NCCN compendium recommended use 1, 2a, or 2b) for the requested indication for the treatment of the patient's diagnosis? .....  Yes  No
- If yes, please specify: \_\_\_\_\_
10. 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 for review.** .....  Yes  No
11. Does the requested quantity (dose) exceed the maximum compendia supported dose in AHFS, DrugDex with 1, 2a, or 2b level of evidence, or NCCN 1, 2a, or 2b recommended use for the requested indication? **Please note, clinical trials, phase III studies, or guidelines must be submitted to support dose.** .....  Yes  No
12. Has the patient been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat the cancer? .....  Yes  No
13. 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
14. 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
15. 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 Infliximab and Infliximab biosimilar requests:**

16. Does the requested quantity (dose) exceed the maximum FDA labeled dose and the maximum compendia supported dose (i.e., AHFS, DrugDex with 1, 2a, or 2b level of evidence, or NCCN 1, 2a, or 2b recommended use) for the requested indication? .....  Yes  No
- If yes, has the patient titrated up to the requested dose due to ineffective symptom control at lower doses? .....  Yes  No
- If yes, is the request either for a dose increase or shortening of dosing interval, NOT both? .....  Yes  No
- If no, is the patient currently being treated with the requested dose? .....  Yes  No

**For Ixifi or Renflexis requests:**

- **Please provide chart notes or medical records to support the answers to the following questions:**

17. Has the patient tried and had an inadequate response to TWO preferred agents (i.e., Avsola, Inflectra, Infliximab [unbranded], Remicade) after at least a 3-month trial per agent? .....  Yes  No
18. Were TWO preferred agents (i.e., Avsola, Inflectra, Infliximab [unbranded], Remicade) discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? .....  Yes  No
19. Does the patient have an intolerance or hypersensitivity to TWO of the preferred agents (i.e., Avsola, Inflectra, Infliximab [unbranded], Remicade) that is not expected to occur with the requested agent? .....  Yes  No
20. Does the patient have an FDA labeled contraindication to ALL of the preferred agents (i.e., Avsola, Inflectra, Infliximab [unbranded], Remicade) that is not expected to occur with the requested agent? .....  Yes  No
21. Are TWO preferred agents (i.e., Avsola, Inflectra, Infliximab [unbranded], Remicade) 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 TWO preferred agents (i.e., Avsola, Inflectra, Infliximab [unbranded], Remicade) 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 TWO preferred agents (i.e., Avsola, Inflectra, Infliximab [unbranded], Remicade) and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? .....  Yes  No

**For Cosentyx vial requests:**

Self-Administered Trial Agent(s)
Cosentyx Sensoready pen 150 mg/mL (1 or 2 pen dose)
Cosentyx UnoReady pen 300 mg/2 mL
Cosentyx prefilled syringe 75 mg/0.5 mL
Cosentyx prefilled syringe 150 mg/mL (1 or 2 syringe dose)
Cosentyx prefilled syringe 300 mg/2 mL

24. Has the patient tried a self-administered Cosentyx agent? .....  Yes  No
25. Is there support for the use of the requested provider-administered product over the self-administered products? .....  Yes  No
- If yes, please provide supporting information: \_\_\_\_\_

- **Please submit chart notes to support the answers to the following questions:**

26. Has the patient tried and had an inadequate response to ONE self-administered Cosentyx agent? .....  Yes  No
27. Was ONE self-administered Cosentyx agent discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? .....  Yes  No
28. Does the patient have an intolerance or hypersensitivity to ONE self-administered Cosentyx agent (that is not expected to occur with the requested agent)? .....  Yes  No
29. Does the patient have an FDA labeled contraindication to ALL self-administered Cosentyx agents (that is not expected to occur with the requested agent)? .....  Yes  No
30. Is ONE self-administered Cosentyx agent 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
31. Is ONE self-administered Cosentyx agent is not in the best interest of the patient based on medical necessity ..  Yes  No
32. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as ONE self-administered Cosentyx agent and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? .....  Yes  No

**Please continue to the next page.**

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**For all requests:**

- **Please select the patient's diagnosis and answer any corresponding questions:**

**Moderately to severely active polyarticular juvenile idiopathic arthritis (PJIA)**

33. 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: \_\_\_\_\_

\_\_\_\_\_

**Chronic severe plaque psoriasis (PS)**

**Moderate to severe plaque psoriasis (PS)**

34. Has the patient tried and had an inadequate response to ONE conventional agent (e.g., acitretin, calcipotriene, calcitriol, coal tar products, 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: \_\_\_\_\_

\_\_\_\_\_

35. Does the patient have severe active 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

36. Does the patient have concomitant severe active 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

**Active ankylosing spondylitis (AS)**

37. Has the patient tried and had an inadequate response to TWO different NSAIDs used in the treatment of AS after at least a 4-week total trial? .....  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: \_\_\_\_\_

\_\_\_\_\_

**Please continue to the next page.**

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**Moderately to severely active Crohn's disease (CD)**

38. Does the patient have severely active Crohn's disease? .....  Yes  No
39. 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, 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: \_\_\_\_\_
- If no, 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: \_\_\_\_\_

**Active non-radiographic axial spondyloarthritis (nr-axSpA)**

40. 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 trial? .....  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: \_\_\_\_\_

**Active psoriatic arthritis (PsA)**

41. 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: \_\_\_\_\_
42. Does the patient have 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
43. Does the patient have concomitant severe psoriasis (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

**Please continue to the next page.**

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**Moderately to severely active rheumatoid arthritis (RA)**

44. Has the patient tried and had an inadequate response to maximally tolerated methotrexate (e.g., titrated to 25 mg weekly) used in the treatment of RA after at least a 3-month duration of therapy? .....  Yes  No
45. Has the patient tried and had an inadequate response to another conventional agent (e.g., hydroxychloroquine, leflunomide, sulfasalazine) used in the treatment of RA 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 (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 conventional agents (i.e., methotrexate, hydroxychloroquine, leflunomide, sulfasalazine) used in the treatment of RA? .....  Yes  No  
 If yes, please specify FDA labeled contraindication: \_\_\_\_\_
- \_\_\_\_\_
46. If the requested agent is Infliximab or an Infliximab biosimilar, will the patient be using a conventional agent (i.e., methotrexate, hydroxychloroquine, leflunomide, sulfasalazine) in combination with the requested agent? ..  Yes  No  
 If no, does the patient have an intolerance, hypersensitivity, or FDA labeled contraindication to ALL conventional agents (i.e., methotrexate, hydroxychloroquine, leflunomide, sulfasalazine)? .....  Yes  No  
 If yes, please explain: \_\_\_\_\_
- \_\_\_\_\_
47. If the requested agent is Simponi ARIA, be using methotrexate in combination with Simponi ARIA?.....  Yes  No  
 If no, does the patient have an intolerance, FDA labeled contraindication, or hypersensitivity to methotrexate? .....  Yes  No  
 If yes, please explain: \_\_\_\_\_
- \_\_\_\_\_

**Giant cell arteritis (GCA)**

48. 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: \_\_\_\_\_
- \_\_\_\_\_

**Moderately to severely active ulcerative colitis (UC)**

49. Does the patient have severely active ulcerative colitis? .....  Yes  No
50. 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, 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: \_\_\_\_\_
- \_\_\_\_\_
- If no, 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: \_\_\_\_\_
- \_\_\_\_\_

**Other (ICD code and description):** \_\_\_\_\_

**Please continue to the next page.**

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**For renewal requests:**

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

**Please fax or mail this form to:**  
 Prime Therapeutics LLC  
 Clinical Review Department  
 2900 Ames Crossing Road Suite 200  
 Eagan, MN 55121

**TOLL FREE**

**Phone:** **Fax: 877.243.6930**  
**BCBSIL: 800.285.9426**  
**BCBSMT: 888.723.7443**  
**BCBSNM: 800.544.1378**  
**BCBSOK: 800.991.5643**  
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