Cimzia

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form along with supporting clinical documentation to Priority Partners, toll-free at 1-866-212-4756 to initiate the review process.** If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4**.**

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ Same as Requesting Provider
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ Same as Referring Provider ❑ Same as Requesting Provider
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

Drug Information:

Strength/Measure _____*Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un

Directions(sig) _____*Route of administration* _____

Dosing frequency _____

What is the ICD-10 code? _____

Site of Service Questions:

A. Indicate the site of service requested:
- ❑ *Ambulatory Surgical (POS Code 24)*
- ❑ *Home (POS Code 12)*
- ❑ *Off Campus Outpatient Hospital (POS Code 19)*
- ❑ *On Campus Outpatient Hospital (POS Code 22)*
- ❑ *Office (POS Code 11)*

B. Is the patient less than 18 years of age?
- ❑ Yes, *skip to Clinical Criteria Questions*
- ❑ No

C. Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (eg acetaminophen, steroids, diphenhydramine, fluids, other pre- medications or slowing of infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.*** ❑ Yes, *skip to Clinical Criteria Questions* ❑ No

Send completed form to: Priority Partners Fax: 1-866-212-4756

D. Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?
ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

E. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

F. Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

G. Has the patient's home been deemed not eligible or appropriate for home infusion services by a home infusion provider? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

H. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes ❑ No

Clinical Criteria Questions:

1. Will the requested drug be used in combination with any other biologic (e.g., Humira) or targeted synthetic drug (e.g., Olumiant, Otezla, Xeljanz) for the same indication?
❒ Yes, *Continue to 2*
❒ No, *Continue to 2*

2. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Olumiant, Xeljanz) associated with an increased risk of tuberculosis?
❒ Yes, *Continue to 6*
❒ No, *Continue to 3*

3. Has the patient had a tuberculosis (TB) test (e.g., tuberculosis skin test [PPD], interferon-release assay [IGRA], chest x-ray) within 6 months of initiating therapy?
❒ Yes, *Continue to 4*
❒ No, *Continue to 4*

4. What were the results of the tuberculosis (TB) test?
❒ Positive for TB, *Continue to 5*
❒ Negative for TB, *Continue to 6*
❒ Unknown, *No further questions*

5. Which of the following applies to the patient?
❒ Patient has latent TB and treatment for latent TB has been initiated, *Continue to 6*

❒ Patient has latent TB and treatment for latent TB has been completed, *Continue to 6*

❒ Patient has latent TB and treatment for latent TB has not been initiated, *Continue to 6*

❒ Patient has active TB, *Continue to 6*

6. What is the diagnosis?

❒ Rheumatoid arthritis, *Continue to 8*

❒ Psoriatic arthritis WITH co-existent plaque psoriasis, *Continue to 7*

❒ Psoriatic arthritis, *Continue to 22*

❒ Ankylosing spondylitis, *Continue to 37*

❒ Non-radiographic axial spondyloarthritis, *Continue to 37*

❒ Crohn's disease, *Continue to 46*

❒ Plaque psoriasis, *Continue to 53*

❒ Immune checkpoint inhibitor-related inflammatory arthritis, *Continue to 68*

❒ Other, please specify: _____, *No further questions*

7. What is the primary diagnosis being treated?

❒ Psoriatic arthritis, *Continue to 22*

❒ Plaque psoriasis, *Continue to 53*

8. Has the patient been diagnosed with moderately to severely active rheumatoid arthritis (RA)?

❒ Yes, *Continue to 9*

❒ No, *Continue to 9*

9. Is the patient an adult (18 years of age or older)?

❒ Yes, *Continue to 10*

❒ No, *Continue to 10*

10. Is the requested drug being prescribed by or in consultation with a rheumatologist?

❒ Yes, *Continue to 11*

❒ No, *Continue to 11*

11. Is this request for continuation of therapy with the requested drug?

❒ Yes, *Continue to 12*

❒ No, *Continue to 15*

12. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 15*

❒ No, *Continue to 13*

❒ Unknown, *Continue to 15*

13. Has the patient achieved or maintained a positive clinical response since starting treatment with the requested drug?

❒ Yes, *Continue to 14*
❒ No, *Continue to 14*

14. Has the patient experienced substantial disease activity improvement (e.g., at least 20% from baseline) in tender joint count, swollen joint count, pain, or disability? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation supporting positive clinical response and substantial disease activity improvement.
❒ Yes, *Continue to 77*
❒ No, *Continue to 77*

15. Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Xeljanz) indicated for treatment of moderately to severely active rheumatoid arthritis (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried.
❒ Yes, *Continue to 77*
❒ No, *Continue to 16*

16. Does the patient meet either of the following: a) the patient was tested for the rheumatoid factor (RF) biomarker and the RF biomarker test was positive, or b) the patient was tested for the anti-cyclic citrullinated peptide (anti-CCP) biomarker and the anti-CCP biomarker test was positive? ***ACTION REQUIRED***: If Yes, please attach laboratory results, chart notes, or medical record documentation of biomarker testing.
❒ Yes, *Continue to 18*
❒ No, *Continue to 17*

17. Has the patient been tested for all of the following biomarkers: a) rheumatoid factor (RF), b) anti-cyclic citrullinated peptide (anti-CCP), and c) C-reactive protein (CRP) and/or erythrocyte sedimentation rate (ESR)? ***ACTION REQUIRED***: If Yes, please attach laboratory results, chart notes, or medical record documentation of biomarker testing.
❒ Yes, *Continue to 18*
❒ No, *Continue to 18*

18. Has the patient experienced an inadequate response after at least 3 months of treatment with methotrexate at a dose greater than or equal to 15 mg per week? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.
❒ Yes, *Continue to 77*
❒ No, *Continue to 19*

19. Has the patient experienced an intolerance to methotrexate? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.
❒ Yes, *Continue to 77*
❒ No, *Continue to 20*

20. Does the patient have a contraindication to methotrexate? ***ACTION REQUIRED***: If Yes, please attach documentation of clinical reason to avoid therapy.
❒ Yes, *Continue to 21*
❒ No, *Continue to 21*

21. Please indicate the contraindication to methotrexate.

❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease, *Continue to 77*

❒ Drug interaction, *Continue to 77*

❒ Risk of treatment-related toxicity, *Continue to 77*

❒ Pregnancy or currently planning pregnancy, *Continue to 77*

❒ Breastfeeding, *Continue to 77*

❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *Continue to 77*

❒ Hypersensitivity, *Continue to 77*

❒ History of intolerance or adverse event, *Continue to 77*

❒ Other, please specify. _____, *Continue to 77*

22. Is the patient an adult (18 years of age or older)?

❒ Yes, *Continue to 23*

❒ No, *Continue to 23*

23. Is the requested drug being prescribed by or in consultation with a rheumatologist or dermatologist?

❒ Yes, *Continue to 24*

❒ No, *Continue to 24*

24. Is this request for continuation of therapy with the requested drug?

❒ Yes, *Continue to 25*

❒ No, *Continue to 28*

25. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 28*

❒ No, *Continue to 26*

❒ Unknown, *Continue to 28*

26. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug?

❒ Yes, *Continue to 27*

❒ No, *Continue to 27*

27. Which of the following has the patient experienced an improvement in from baseline? ***ACTION REQUIRED***: Please attach chart notes or medical record documentation supporting positive clinical response.

❒ Number of swollen joints ***ACTION REQUIRED****: Submit supporting documentation, Continue to 77*

❒ Number of tender joints ***ACTION REQUIRED****: Submit supporting documentation, Continue to 77*

❒ Dactylitis ***ACTION REQUIRED****: Submit supporting documentation, Continue to 77*

❒ Enthesitis ***ACTION REQUIRED****: Submit supporting documentation, Continue to 77*

❒ Axial disease ***ACTION REQUIRED****: Submit supporting documentation, Continue to 77*

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❒ Skin and/or nail involvement ***ACTION REQUIRED****: Submit supporting documentation, Continue to 77*

❒ None of the above, *Continue to 77*

28. Has the patient been diagnosed with active psoriatic arthritis (PsA)?
❒ Yes, *Continue to 29*
❒ No, *Continue to 29*

29. Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Otezla) indicated for active psoriatic arthritis (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried.
❒ Yes, *Continue to 77*
❒ No, *Continue to 30*

30. What is the patient's disease severity?

❒ Mild to moderate, *Continue to 31*

❒ Severe, *Continue to 77*

31. Does the patient have enthesitis or predominantly axial disease?
❒ Yes, *Continue to 77*
❒ No, *Continue to 32*

32. Has the patient had an inadequate response to methotrexate, leflunomide, or another conventional synthetic drug (e.g., sulfasalazine) administered at an adequate dose and duration? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.
❒ Yes, *Continue to 77*
❒ No, *Continue to 33*

33. Has the patient had an intolerance to methotrexate, leflunomide, or another conventional synthetic drug (e.g., sulfasalazine)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.
❒ Yes, *Continue to 77*
❒ No, *Continue to 34*

34. Does the patient have a contraindication to methotrexate or leflunomide? ***ACTION REQUIRED***: If Yes, please attach documentation of clinical reason to avoid therapy.
❒ Yes, *Continue to 35*
❒ No, *Continue to 36*

35. Please indicate the contraindication to methotrexate or leflunomide.

❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease, *Continue to 77*

❒ Drug interaction, *Continue to 77*

❒ Risk of treatment-related toxicity, *Continue to 77*

❒ Pregnancy or currently planning pregnancy, *Continue to 77*

❒ Breastfeeding, *Continue to 77*

❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *Continue to 77*

❒ Hypersensitivity, *Continue to 77*

❒ History of intolerance or adverse event, *Continue to 77*

❒ Other, please specify: _____, *Continue to 77*

36. Does the patient have a contraindication to another conventional synthetic drug (e.g., sulfasalazine)? ***ACTION REQUIRED***: If Yes, please attach documentation of clinical reason to avoid therapy.
❒ Yes, *Continue to 77*
❒ No, *Continue to 77*

37. Is the patient an adult (18 years of age or older)?
❒ Yes, *Continue to 38*
❒ No, *Continue to 38*

38. Is the requested drug being prescribed by or in consultation with a rheumatologist?
❒ Yes, *Continue to 39*
❒ No, *Continue to 39*

39. Is this request for continuation of therapy with the requested drug?
❒ Yes, *Continue to 40*
❒ No, *Continue to 43*

40. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 43*

❒ No, *Continue to 41*

❒ Unknown, *Continue to 43*

41. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug?
❒ Yes, *Continue to 42*
❒ No, *Continue to 42*

42. Which of the following has the patient experienced an improvement in from baseline? ***ACTION REQUIRED***: Please attach chart notes or medical records supporting positive clinical response.

❒ Functional status ***ACTION REQUIRED****: Submit supporting documentation, Continue to 77*

❒ Total spinal pain ***ACTION REQUIRED****: Submit supporting documentation, Continue to 77*
❒ Inflammation (e.g., morning stiffness) ***ACTION REQUIRED****: Submit supporting documentation, Continue to 77*

❒ None of the above, *Continue to 77*

43. Has the patient been diagnosed with active ankylosing spondylitis (AS) or active non-radiographic axial spondyloarthritis (nr-axSpA)?

❒ Yes - Active ankylosing spondylitis, *Continue to 44*

❒ Yes - Active non-radiographic axial spondyloarthritis, *Continue to 44*

❒ No, *Continue to 37*

44. Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Xeljanz) indicated for treatment of active ankylosing spondylitis or active non-radiographic axial spondyloarthritis (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried.
❒ Yes, *Continue to 77*
❒ No, *Continue to 45*

45. Has the patient experienced an inadequate response with at least TWO non-steroidal anti-inflammatory drugs (NSAIDs), or has an intolerance or contraindication to at least two NSAIDs? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is not advisable, please attach documentation of clinical reason to avoid therapy.
❒ Yes, *Continue to 77*
❒ No, *Continue to 77*

46. Has the patient been diagnosed with moderately to severely active Crohn's disease (CD)?
❒ Yes, *Continue to 47*
❒ No, *Continue to 47*

47. Is the patient an adult (18 years of age or older)?
❒ Yes, *Continue to 48*
❒ No, *Continue to 48*

48. Is the requested drug being prescribed by or in consultation with a gastroenterologist?
❒ Yes, *Continue to 49*
❒ No, *Continue to 49*

49. Is this request for continuation of therapy with the requested drug?
❒ Yes, *Continue to 50*
❒ No, *Continue to 77*

50. Has the patient achieved or maintained remission? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation of remission.
❒ Yes, *Continue to 77*
❒ No, *Continue to 51*

51. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug?
❒ Yes, *Continue to 52*
❒ No, *Continue to 52*

52. Which of the following has the patient experienced an improvement in from baseline? ***ACTION REQUIRED***: Please attach chart notes or medical record documentation supporting positive clinical response to therapy.

❒ Abdominal pain or tenderness ***ACTION REQUIRED****: Submit supporting documentation, Continue to 77*

❒ Diarrhea ***ACTION REQUIRED****: Submit supporting documentation, Continue to 77*

❒ Body weight ***ACTION REQUIRED****: Submit supporting documentation, Continue to 77*

❒ Abdominal mass ***ACTION REQUIRED****: Submit supporting documentation, Continue to 77*

❒ Hematocrit ***ACTION REQUIRED****: Submit supporting documentation, Continue to 77*

❒ Appearance of the mucosa on endoscopy, computed tomography enterography (CTE), magnetic resonance enterography (MRE), or intestinal ultrasound ***ACTION REQUIRED****: Submit supporting documentation, Continue to 77*

❒ Improvement on a disease activity scoring tool (e.g., Crohn's Disease Activity Index [CDAI] score) ***ACTION REQUIRED****: Submit supporting documentation, Continue to 77*

❒ None of the above, *Continue to 77*

53. Has the patient been diagnosed with moderate to severe plaque psoriasis?
❒ Yes, *Continue to 54*
❒ No, *Continue to 54*

54. Is the patient an adult (18 years of age or older)?
❒ Yes, *Continue to 55*
❒ No, *Continue to 55*

55. Is the requested drug being prescribed by or in consultation with a dermatologist?
❒ Yes, *Continue to 56*
❒ No, *Continue to 56*

56. Is this request for continuation of therapy with the requested drug?
❒ Yes, *Continue to 57*
❒ No, *Continue to 61*

57. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 61*

❒ No, *Continue to 58*

❒ Unknown, *Continue to 61*

58. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug?
❒ Yes, *Continue to 59*
❒ No, *Continue to 59*

59. Has the patient experienced a reduction in body surface area (BSA) affected from baseline? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation of decreased body surface area affected.
❒ Yes, *Continue to 77*
❒ No, *Continue to 60*

60. Has the patient experienced an improvement in signs and symptoms of the condition from baseline (e.g., itching, redness, flaking, scaling, burning, cracking, pain)? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation of improvement in signs and symptoms.
❒ Yes, *Continue to 77*
❒ No, *Continue to 77*

61. Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Sotyktu, Otezla) indicated for the treatment of moderate to severe plaque psoriasis (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED***: If Yes, attach chart notes, medical record documentation, or claims history supporting previous medications tried.
❒ Yes, *Continue to 77*
❒ No, *Continue to 62*

62. Are crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) affected? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation of affected areas.
❒ Yes, *Continue to 77*
❒ No, *Continue to 63*

63. Is the percentage of body surface area (BSA) affected (prior to starting the requested medication) less than 3%?
❒ Yes, *Continue to 64*
❒ No, *Continue to 64*

64. What is the percentage of body surface area (BSA) affected (prior to starting the requested medication)? Indicate percentage. ***ACTION REQUIRED***: Please attach chart notes or medical record documentation of body surface area affected.
❒ Greater than or equal to 3% to less than 10% of body surface area (BSA) _____%
ACTION REQUIRED*: Submit supporting documentation, Continue to 65*
❒ Greater than or equal to 10% of body surface area (BSA) _____% ***ACTION REQUIRED****: Submit supporting documentation, Continue to 77*

65. Has the patient experienced an inadequate response, or has an intolerance to phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.
❒ Yes, *Continue to 77*
❒ No, *Continue to 66*

66. Does the patient have a clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine, and acitretin? ***ACTION REQUIRED***: If Yes, please attach documentation of clinical reason to avoid therapy.
❒ Yes, *Continue to 67*
❒ No, *Continue to 67*

67. Please indicate the clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine, and acitretin.

❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease, *Continue to 77*

❒ Drug interaction, *Continue to 77*

❒ Risk of treatment-related toxicity, *Continue to 77*

❒ Pregnancy or currently planning pregnancy, *Continue to 77*

❒ Breastfeeding, *Continue to 77*

❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *Continue to 77*

❒ Hypersensitivity, *Continue to 77*

❒ History of intolerance or adverse event, *Continue to 77*

❒ Other, please specify: _____, *Continue to 77*

68. Is the requested drug being prescribed by or in consultation with an oncologist, hematologist, or rheumatologist?

❒ Yes, *Continue to 69*

❒ No, *Continue to 69*

69. Is this request for continuation of therapy with the requested drug?

❒ Yes, *Continue to 70*

❒ No, *Continue to 72*

70. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 72*

❒ No, *Continue to 71*

❒ Unknown, *Continue to 72*

71. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation supporting positive clinical response.

❒ Yes, *Continue to 77*

❒ No, *Continue to 77*

72. Does the patient have severe immunotherapy-related inflammatory arthritis?

❒ Yes, *Continue to 73*

❒ No, *Continue to 73*

73. Has the patient had an inadequate response to corticosteroids? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy.

❒ Yes, *Continue to 77*

❒ No, *Continue to 74*

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74. Has the patient had an inadequate response to a conventional synthetic drug (e.g., methotrexate, sulfasalazine, leflunomide, hydroxychloroquine)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy.
❒ Yes, *Continue to 77*
❒ No, *Continue to 75*

75. Does the patient have an intolerance or contraindication to corticosteroids? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is if not advisable, please attach documentation of clinical reason to avoid therapy.
❒ Yes, *Continue to 76*
❒ No, *Continue to 76*

76. Does the patient have an intolerance or contraindication to a conventional synthetic drug (e.g., methotrexate, sulfasalazine, leflunomide, hydroxychloroquine)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is if not advisable, please attach documentation of clinical reason to avoid therapy.
❒ Yes, *Continue to 77*
❒ No, *Continue to 77*

77. What is the diagnosis?

❒ Rheumatoid arthritis, *Continue to 78*

❒ Psoriatic arthritis WITH co-existent plaque psoriasis, *Continue to 88*

❒ Psoriatic arthritis, *Continue to 78*

❒ Ankylosing spondylitis, *Continue to 78*

❒ Non-radiographic axial spondyloarthritis, *Continue to 78*

❒ Crohn's disease, *Continue to 93*

❒ Plaque psoriasis, *Continue to 88*

❒ Immune checkpoint inhibitor-related inflammatory arthritis, *Continue to 99*

78. Is the patient currently receiving the requested drug?
❒ Yes, *Continue to 80*
❒ No, *Continue to 79*

79. Is a loading dose prescribed?
❒ Yes, *Continue to 84*
❒ No, *Continue to 80*

80. Does the prescribed maintenance dose exceed 200 mg?
❒ Yes, *Continue to 82*
❒ No, *Continue to 81*

81. Is the prescribed frequency for the maintenance dose more frequent than one dose every other week?

❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

82. Does the prescribed maintenance dose exceed 400 mg?
❒ Yes, *Continue to 83*
❒ No, *Continue to 83*

83. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

84. Does the prescribed dose exceed a loading dose of 400 mg at weeks 0, 2, and 4, and a maintenance dose of 200 mg thereafter?
❒ Yes, *Continue to 86*
❒ No, *Continue to 85*

85. Is the prescribed frequency for the maintenance dose more frequent than one dose every other week?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

86. Does the prescribed dose exceed a loading dose of 400 mg at weeks 0, 2, and 4, and a maintenance dose of 400 mg thereafter?
❒ Yes, *Continue to 87*
❒ No, *Continue to 87*

87. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

88. Is the patient currently receiving the requested drug?
❒ Yes, *Continue to 89*
❒ No, *Continue to 91*

89. Does the prescribed maintenance dose exceed 400 mg?
❒ Yes, *Continue to 90*
❒ No, *Continue to 90*

90. Is the prescribed frequency for the maintenance dose more frequent than one dose every other week?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

91. Does the prescribed dose exceed 400 mg?
❒ Yes, *Continue to 92*
❒ No, *Continue to 92*

92. Is the prescribed frequency more frequent than one dose every other week?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

93. Is the patient currently receiving the requested drug?
❒ Yes, *Continue to 95*
❒ No, *Continue to 94*

94. Is a loading dose prescribed?
❒ Yes, *Continue to 97*
❒ No, *Continue to 95*

95. Does the prescribed maintenance dose exceed 400 mg?
❒ Yes, *Continue to 96*
❒ No, *Continue to 96*

96. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

97. Does the prescribed dose exceed a loading dose of 400 mg at weeks 0, 2, and 4, and a maintenance dose of 400 mg thereafter?
❒ Yes, *Continue to 98*
❒ No, *Continue to 98*

98. Is the prescribed frequency for the maintenance dose more frequent than one dose every 4 weeks?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

99. Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?
❒ Yes, *Continue to 100*
❒ No, *Continue to 100*

100. Is the patient currently receiving the requested drug?
❒ Yes, *Continue to 102*
❒ No, *Continue to 101*

101. Is a loading dose prescribed?
❒ Yes, *Continue to 104*
❒ No, *Continue to 102*

102. Does the prescribed maintenance dose exceed 200 mg?
❒ Yes, *Continue to 103*
❒ No, *Continue to 103*

103. Is the prescribed frequency for the maintenance dose more frequent than one dose every other week?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

104. Does the prescribed dose exceed a loading dose of 400 mg at weeks 0, 2, and 4, and a maintenance dose of 200 mg thereafter?
❒ Yes, *Continue to 105*
❒ No, *Continue to 105*

105. Is the prescribed frequency for the maintenance dose more frequent than one dose every other week?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by Priority Partners.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

Send completed form to: Priority Partners Fax: 1-866-212-4756

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