Pennsylvania
Department of Human Services

Office of Medical Assistance Programs
Bureau of Fee-for-Service Programs, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

# CYTOKINE AND CAM ANTAGONISTS PRIOR AUTHORIZATION FORM *(form effective 1/6/2025)*

Prior authorization guidelines for **Cytokine and CAM Antagonists** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at https://www.pa.gov/en/agencies/dhs/resources/for-providers/ma-for-providers/pharmacy-services.html.

| | | | |
|---|---|---|---|
| ☐New request ☐Renewal request | # of pages: _____ | Prescriber name: | |
| Name of office contact: | | Specialty: | |
| Contact's phone number: | | NPI: | State license #: |
| LTC facility contact/phone: | | Street address: | |
| Beneficiary name: | | City/state/zip: | |
| Beneficiary ID#: | DOB: | Phone: | Fax: |

## CLINICAL INFORMATION

| | | | |
|---|---|---|---|
| STARTER PACK requested (drug name / strength / formulation [pen, syringe, tablet, etc.]): | | MAINTENANCE product/packaging requested (drug name / strength / formulation [pen, syringe, tablet, etc.]): | |
| Quantity per fill: | Refills: | Quantity per fill: | Refills: |
| Directions: | | Directions: | |
| Diagnosis (*submit documentation*): | | Dx code (*required*): | Beneficiary weight: |
| Is the beneficiary currently being treated with the requested medication? | | ☐Yes – date of last dose: _____ *Submit documentation.*<br>☐No | |
| Is the requested medication prescribed by or in consultation with a specialist (eg, rheumatologist, dermatologist, gastroenterologist, etc.)? | | ☐Yes ☐No *If prescriber is not a specialist, submit documentation of consultation.* | |

Complete all sections that apply to the beneficiary and this request.
*Check all that apply and submit documentation for each item.*

## INITIAL requests

### DRUG

1. Requested drug is NON-PREFERRED on the Statewide PDL:
   ☐Tried and failed or has a contraindication or intolerance to the preferred drugs in this class approved or medically accepted for the beneficiary's condition *(Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*
2. Requested drug is BIMZELX (bimekizumab), OTEZLA (apremilast), or SILIQ (brodalumab):
   ☐Was evaluated for history of prior suicide attempt, bipolar disorder, or major depressive disorder
3. Requested drug is an ORAL JAK INHIBITOR (eg, Olumiant [baricitinib], Rinvoq [upadacitinib], Xeljanz [tofacitinib]):
   ☐Tried and failed at least one TNF blocker or other biologic as recommended in the JAK inhibitor's package labeling

☐ Has a contraindication or an intolerance to TNF blockers or other biologics as recommended in the JAK inhibitor's package labeling

DIAGNOSIS

1. ALL diagnoses:
   - ☐ Screened for hepatitis B virus infection (surface antigen, surface antibody, and core antibody) *(if recommended in the FDA-approved package labeling)*
   - ☐ Screened for tuberculosis *(if recommended in the FDA-approved package labeling)*
2. Adult-onset Still's disease (AOSD):
   - ☐ Has predominantly systemic AOSD AND:
     - ☐ Has steroid-dependent AOSD
     - ☐ Tried and failed or has a contraindication or an intolerance to systemic glucocorticoids
   - ☐ Has predominantly joint AOSD AND:
     - ☐ Tried and failed or has a contraindication or an intolerance to conventional DMARDs (eg, MTX)
3. Alopecia areata:
   - ☐ Has alopecia universalis
   - ☐ Has >50% scalp involvement or alopecia totalis
   - ☐ Has alopecia that causes significant disability or impaired physical, mental, or psychosocial functioning
   - ☐ Has a current episode of alopecia areata that has lasted at least 6 months
4. Ankylosing spondylitis & non-radiographic axial spondyloarthritis:
   - ☐ Tried and failed a 2-week trial of or has a contraindication or an intolerance to 2 different oral NSAIDs
5. Behçet's syndrome:
   - ☐ Has recurrent oral ulcers associated with Behçet's syndrome
   - ☐ Tried and failed or has a contraindication or an intolerance to a topical corticosteroid (eg, triamcinolone dental paste)
   - ☐ Tried and failed a 3-month trial of colchicine at maximally tolerated doses or has a contraindication or an intolerance to colchicine
6. Crohn's disease (CD):
   - ☐ Has moderate-to-severe CD AND:
     - ☐ Tried and failed to achieve remission with or has a contraindication or an intolerance to an induction course of corticosteroids
     - ☐ Tried and failed to maintain remission with or has a contraindication or an intolerance to conventional immunomodulators (eg, AZA, 6-MP, MTX)
   - ☐ Has CD that is associated with high-risk or poor prognostic features
   - ☐ Has achieved remission with the requested medication AND:
     - ☐ Will be using the requested medication as maintenance therapy to maintain remission
7. Familial Mediterranean fever:
   - ☐ Tried and failed a 3-month trial of colchicine at maximally tolerated doses or has a contraindication or an intolerance to colchicine
8. Generalized pustular psoriasis (GPP):
   - ☐ Request is for Spevigo (spesolimab) intravenous AND:
     - ☐ Is being treated for a GPP flare
     - ☐ One of the following:
       - ☐ Beneficiary has received a single dose of spesolimab for the current GPP flare AND:
         - ☐ Continues to experience moderate to severe GPP flare symptoms since the previous dose
       - ☐ Beneficiary has not received a dose of spesolimab for the current GPP flare AND:
         - ☐ Is experiencing a moderate to severe GPP flare that warrants rapid stabilization or improvement
   - ☐ Request is for Spevigo (spesolimab) subcutaneous AND:
     - ☐ Has a history of at least one GPP flare
     - ☐ Is using subcutaneous spesolimab for the prevention of GPP flares

9. Giant cell arteritis (GCA):
   - ☐ Tried and failed or has a contraindication or an intolerance to systemic glucocorticoids
   - ☐ Is at high risk for glucocorticoid-related complications
   - ☐ Has steroid-dependent GCA

10. Gout flares:
   - ☐ Tried and failed maximally tolerated doses of or has a contraindication or an intolerance to NSAIDs
   - ☐ Tried and failed maximally tolerated doses of or has a contraindication or an intolerance to colchicine
   - ☐ Tried and failed maximally tolerated doses of or has a contraindication or an intolerance to corticosteroids
   - ☐ Has a medical reason why repeated courses of corticosteroids are not appropriate

11. Hidradenitis suppurativa (HS):
   - ☐ Has Hurley stage II or stage III HS
   - ☐ Is a candidate for or has a history of surgical intervention for HS
   - ☐ Tried and failed a 3-month trial of or has a contraindication or an intolerance to topical clindamycin
   - ☐ Tried and failed or has a contraindication or an intolerance to systemic antibiotics (eg, doxycycline, minocycline, tetracycline, clindamycin)

12. Juvenile idiopathic arthritis (JIA):
   - ☐ Has systemic JIA with active systemic features
   - ☐ Has JIA associated with any of the following:
     - ☐ Positive anti-CCP antibodies
     - ☐ Positive rheumatoid factor
     - ☐ Presence of joint damage
     - ☐ High risk of disabling joint damage
     - ☐ High disease activity
     - ☐ Involvement of high-risk joints (cervical spine, hip, wrist)
   - ☐ Tried and failed a 3-month trial of or has a contraindication or an intolerance to conventional DMARDs (eg, MTX)
   - ☐ Has active sacroiliitis and/or enthesitis AND:
     - ☐ Tried and failed a 2-week trial of or has a contraindication or an intolerance to oral NSAIDs

13. Plaque psoriasis:
   - ☐ Has a BSA of ≥3% that is affected
   - ☐ Has involvement of critical areas of the body (eg, skin folds, face, genitals)
   - ☐ Has psoriasis that causes significant disability or impaired physical, mental, or psychosocial functioning
   - ☐ Has moderate-to-severe nail psoriasis
   - ☐ Tried and failed a 4-week trial of or has a contraindication or an intolerance to topical corticosteroids
   - ☐ Tried and failed an 8-week trial of or has a contraindication or an intolerance to non-steroid topical medications (eg, anthralin, calcineurin inhibitor, tazarotene, etc)

14. Polymyalgia rheumatica (PMR):
   - ☐ Tried and failed or has a contraindication or an intolerance to systemic glucocorticoids
   - ☐ Has steroid-dependent PMR

15. Psoriatic arthritis (PsA):
   - ☐ Tried and failed an 8-week trial of or has a contraindication or an intolerance to conventional DMARDs (eg, AZA, leflunomide, MTX, SSZ)
   - ☐ Has predominantly axial PsA, dactylitis, and/or enthesitis
   - ☐ Has severe PsA
   - ☐ Has comorbid moderate-to-severe nail psoriasis
   - ☐ Has comorbid active inflammatory bowel disease

16. Rheumatoid arthritis:
   - ☐ Tried and failed a 3-month trial of or has a contraindication or an intolerance to conventional DMARDs (eg, AZA, leflunomide, MTX, etc)

17. Sarcoidosis:
   - ☐ Tried and failed or has a contraindication or an intolerance to systemic glucocorticoids
   - ☐ Has steroid-dependent sarcoidosis
   - ☐ Tried and failed a conventional DMARD (eg, AZA, leflunomide, MTX, mycophenolate) or has a contraindication or an intolerance to

conventional DMARDs

18. Ulcerative colitis (UC):
- ☐ Has moderate-to-severe UC
- ☐ Has UC associated with multiple poor prognostic factors
- ☐ Tried and failed to achieve remission with or has a contraindication or an intolerance to an induction course of corticosteroids
- ☐ Tried and failed to maintain remission with or has a contraindication or an intolerance to conventional immunomodulators (eg, AZA, cyclosporine, 6-MP, MTX)
- ☐ Has achieved remission with the requested medication AND:
  - ☐ Will be using the requested medication as maintenance therapy to maintain remission

19. Uveitis (non-infectious):
- ☐ Has comorbid juvenile idiopathic arthritis
- ☐ Has comorbid Behçet's syndrome
- ☐ Has steroid-dependent uveitis
- ☐ Tried and failed or has a contraindication or an intolerance to systemic, topical, intraocular, or periocular corticosteroids
- ☐ Tried and failed or has a contraindication or an intolerance to conventional systemic immunosuppressives (eg, AZA, MTX, MMF, etc)

20. Other diagnosis: _____

☐ List other treatments tried (including start/stop dates, dose, outcomes): _____

_____

## RENEWAL requests

☐ Experienced an improvement in disease severity or level of functioning since starting therapy with the requested medication

☐ Is prescribed an increased dose or more frequent administration of the requested medication

☐ Requested drug is BIMZELX (bimekizumab), OTEZLA (apremilast), or SILIQ (brodalumab):
- ☐ Was recently reevaluated for behavioral and mood changes

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

| Prescriber Signature: | Date: |
|---|---|
| | |