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 7/6/2026)*

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/agencies/dhs/resources/for-providers/ma-for-providers/pharmacy-services.

☐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.* ☐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 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)
   - ☐ Screened for tuberculosis

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
   - ☐ 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) AND:
     - ☐ Beneficiary has received a single dose of Spevigo (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 Spevigo (spesolimab) for the current GPP flare AND:
       - ☐ Is experiencing a moderate to severe GPP flare that warrants rapid stabilization or improvement

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 one of the following topical corticosteroid regimens:
  - ☐ 8 weeks of a medium potency topical corticosteroid
  - ☐ 4 weeks of a medium potency topical corticosteroid AND 4 weeks of a high potency topical corticosteroid
- ☐ Has a contraindication or an intolerance to medium and high potency topical corticosteroids
- ☐ Tried and failed an 8-week trial of non-steroid topical drugs (eg, anthralin, calcineurin inhibitor, tazarotene, etc)
- ☐ Has a contraindication or an intolerance to all non-steroid topical drugs (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 mild UC associated with multiple poor prognostic factors
- ☐ 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**:

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