Cytokine and CAM – Miscellaneous Agents
Clinical Prior Authorization (PA) Request Form
CT Medical Assistance Program
To Be Completed By Prescriber

Prescriber Information	Patient Information
Prescriber's NPI:	Patient's Medicaid ID Number:
Prescriber Name:	Patient Name:
Prescriber Subspecialty:	Patient DOB:
Phone ( )	Patient Current Weight:
Fax ( )	Patient Primary ICD Diagnosis Code:
Prescription Information	
Drug, Strength, and Dosage Form Requested:	Frequency of Dosing:
□ New therapy □ Continuation	Quantity Requested:

Preferred Agents:	Non-Preferred Agents:
ORENCIA CLICKJECT, SYRINGE	ENTYVIO PEN, VIAL
OTEZLA IR TABLET	ORENCIA VIAL
	OTEZLA XR TABLET
PREFERRED IL12/IL23 AGENTS	SOTYKTU TABLET
(Ustekinumab biosimilars listed for reference):	SPEVIGO SYRINGE, VIAL
PYZCHIVA SYRINGE, SUBCUTANEOUS VIAL	UPLIZNA VIAL
SELARSDI SYRINGE, VIAL	VELSIPITY TABLET
STEQEYMA SYRINGE, VIAL	
PREFERRED TNFi AGENTS (listed for reference):	
ADALIMUMAB-ADAZ PEN, SYRINGE	
ENBREL DISP SYRINGE, KIT, PEN	
ENBREL MINI CARTRIDGE, VIAL	
HADLIMA PUSHTOUCH, SYRINGE	
HUMIRA KIT, PEN INJECTION KIT	
INFLIXIMAB VIAL	

Clinical Information

(attach supporting documentation, **required**)

Note: Using samples to initiate therapy does not meet authorization requirements

1. Prescribed by or in consultation with a rheumatologist, dermatologist, gastroenterologist or any other specialist familiar with the treated disease state (or as appropriate for diagnosis)? o Please Specify:_____	□ Yes □ No
2. Is patient using in combination with another targeted immunomodulator or other potent immunosuppressants (i.e. biologic disease-modifying antirheumatic drugs or Janus kinase inhibitors)? o Please specify alternate agent:_____	□ Yes □ No
3. Does patient have untreated latent Tuberculosis (TB), active Tuberculosis, active Hepatitis B or other active infection prior to initiation? o Please specify infection:_____	□ Yes □ No
4. Patient has trialed and failed ONE preferred tumor necrosis factor inhibitor (TNFi) **OR** preferred USTEKINUMAB biosimilar for a minimum of 30 days **OR** Documented Adverse Event/Adverse Drug Reaction or Contraindication to ALL preferred agents: ▪ Preferred agent trialed: _____ ▪ Trial Dates: _____ ▪ Reason for Failure: _____ ▪ If Adverse Reaction, Adverse Event, or Contraindication, please specify details: _____ _____	□ Yes □ No □ N/A
5. Patient has trialed and failed preferred ORENCIA Clickject/Syringe or OTEZLA IR Tablet for a minimum of 30 days **OR** Documented Adverse Event/Adverse Drug Reaction or Contraindication to either agent: ▪ Preferred agent trialed: _____ ▪ Trial Dates: _____ ▪ Reason for Failure: _____ ▪ If Adverse Reaction, Adverse Event, or Contraindication, please specify details: _____ _____	□ Yes □ No □ N/A

For Initial Approval:
Medication Requested and Documented diagnosis of ONE of the following:

(attach supporting documentation, **required**)

Entyvio (vedolizumab) (18+ years of age):
 	
• Patient has a documented diagnosis of ONE of the following:
  o Crohn's Disease (CD)
  o Ulcerative Colitis (UC) **AND**
• Failure to achieve the desired therapeutic outcome following a trial of at least ONE preferred tumor necrosis factor inhibitor (TNFi) OR preferred USTEKINUMAB biosimilar (as outlined above in Question 4 of the Clinical Information section)
	□ Yes □ No

Orencia Vial (abatacept):
 	
• Patient has a documented diagnosis of ONE of the following:
  o Rheumatoid Arthritis (RA) (18+ years of age)
  o Polyarticular Juvenile Idiopathic Arthritis (pJIA) (2+ years of age)
  o Psoriatic Arthritis (PsA) (2+ years of age)
  o Prophylaxis for Acute Graft versus Host Disease (GVHD) (2+ years of age) **AND**
• Prescriber attests to the following (provide documentation):
  o Patient has been screened for tuberculosis (TB)
  o For use in Prophylaxis for Acute Graft versus Host Disease (GVHD)
  ▪ Must use in combination with a calcineurin inhibitor and methotrexate
  ▪ Patient is undergoing hematopoietic stem cell transplantation
  o For all approved indications besides GVHD: Failure to achieve the desired therapeutic outcome following a trial of a preferred ORENCIA formulation (as outlined above in Question 5 of the Clinical Information section) OR
  o **Documented medical reason patient cannot use preferred Subcutaneous Orencia:**
  _____
  _____
	□ Yes □ No

Otezla XR (apremilast): • Patient has a documented diagnosis of ONE of the following: o Active Psoriatic Arthritis (PsA) (6+ years of age and weigh at least 50 kg)	□ Yes □ No

○ Plaque Psoriasis (PsO) (18+ years of age) and is a candidate for systemic therapy or phototherapy ○ Moderate-to-Severe Plaque Psoriasis (PsO) (6+ years of age and weigh at least 50 kg) and is a candidate for systemic therapy or phototherapy ○ Oral Ulcers Associated with Behçet's Disease (18+ years of age) **AND** • Failure to achieve the desired therapeutic outcome following a trial of a preferred OTEZLA formulation (as outlined above in Question 5 of the Clinical Information section) **AND** • **Documented medical reason patient cannot use preferred Otezla Immediate Release:_____** _____	
Sotyktu (deucravacitinib) (18+ years of age): • Patient has a documented diagnosis of ONE of the following: ○ Active Psoriatic Arthritis ○ Moderate-to-Severe Plaque Psoriasis (PsO) and is a candidate for systemic therapy or phototherapy **AND** • Failure to achieve the desired therapeutic outcome following a trial of at least ONE preferred Cytokine and CAM Antagonist agent FDA approved for the treated disease state (as outlined above in Question 4 or 5 of the Clinical Information section) **AND** • Prescriber attests to ALL the following (provide documentation): ○ Patient has been screened for tuberculosis (TB) ○ Liver function tests confirm patient does NOT have severe hepatic impairment (Child-Pugh C) *(NOTE: Sotyktu is not recommended in patients with severe hepatic impairment)*	□ Yes □ No
Spevigo (spesolimab-sbzo) (12+ years of age and weigh at least 40 kg): • Patient has a documented diagnosis of Generalized Pustular Psoriasis (GPP) **AND** • Prescriber attests to ALL the following (provide documentation): ○ Patient has been screened for tuberculosis (TB) ○ Intravenous formulation is limited to treatment of acute flares *(Clinical PA approval limited to 1 month for flares)* ○ Subcutaneous formulation is limited to use in the prevention of flares	□ Yes □ No
Uplizna (inebilizumab-cdon) (18+ years of age): • Patient has a documented diagnosis of ONE of the following:	□ Yes □ No

○ Generalized myasthenia gravis in patients who are anti-acetylcholine receptor (AChR) or anti-muscle specific tyrosine kinase (MuSK) antibody positive ○ Neuromyelitis Optica Spectrum Disorder (NMOSD) and is Anti-Aquaporin-4 (AQP4) Antibody positive ○ Immunoglobulin G4-Related Disease (IgG4-RD) **AND** • Patient does NOT have active hepatitis B, active or untreated latent tuberculosis, or other active infections **AND** • **For immunoglobulin G4-related disease**: Patient has experienced a prior disease flare requiring treatment with corticosteroids OR has had an adverse reaction/adverse event or contraindication to corticosteroids ○ Explanation of Contraindication or Failure to Corticosteroids: _____ _____	
Velsipity (etrasimod) (18+ years of age): • Patient has a documented diagnosis of Moderate-to-Severe Active Ulcerative Colitis (UC) **AND** • Failure to achieve the desired therapeutic outcome following a trial of at least ONE preferred tumor necrosis factor inhibitor (TNFi) OR preferred ustekinumab biosimilar (as outlined above in Question 4 of the Clinical Information section) **AND** • Prescriber attests to ALL the following (provide documentation): ○ The following assessments have been completed prior to initiation: ▪ Complete blood count ▪ Cardiac evaluation ▪ Liver function tests ▪ Ophthalmic assessment ○ Patient has NOT experienced ANY of the following events in the last 6 months: ▪ Myocardial Infarction ▪ Unstable Angina Pectoris ▪ Stroke ▪ Transient Ischemic Attack ▪ Decompensated Heart Failure Requiring Hospitalization ▪ Class III or IV Heart Failure ○ Patient does NOT have a history or presence of the following unless the patient has a	□ Yes □ No

functioning pacemaker: ▪ Mobitz Type II Second-Degree or Third-Degree Atrioventricular (AV) Block ▪ Sick Sinus Syndrome ▪ Sino-Atrial Block	

Renewal Information

(attach supporting documentation, **required**)

Note: Using samples to initiate therapy does not meet renewal authorization requirements

• Has the patient previously met the required criteria set forth in Initial Approval Section above? o Previous Approved Prior Authorization Number: _____ o Approval Dates: _____	□ Yes □ No
• Patients' clinical response to treatment and ongoing safety has been documented and monitored	□ Yes □ No
• Prescriber attests that the patient has a continued need for therapy and is compliant with current regimen	□ Yes □ No
• For specific formulation requests: o **For non-preferred OTEZLA XR requests when a therapeutically equivalent OTEZLA is preferred:** Provider must provide a documented medical reason the preferred Otezla formulation cannot be used: _____ o **For non-preferred ORENCIA Vial requests when a therapeutically equivalent ORENCIA Clickject/Syringe is preferred:** Provider must provide a documented medical reason the preferred Orencia formulation cannot be used: _____	

Please Note: Pharmacies should not be contacting prescribers to provide pre-signed PA forms or submitting pre-signed forms for PA, nor should prescribing providers be requesting that pharmacies perform PA activities for them. PA requests must originate from the prescriber, and only the prescriber should sign the form at the time of PA submission.
I certify that documentation is maintained in my files and the information given is true and accurate for the medication requested, subject to penalty under section 17b-99 of the Connecticut General Statutes and sections 17-83k-1- to 17-83k-7, inclusive, of the Regulations of Connecticut State Agencies. I certify that the above-referenced member is a patient under my clinic's/practice's ongoing care. I understand that a prior authorization may not exceed one (1) year from the date of fill for non- controlled medications. Authorizations for Early Refill Requests are valid one time only.

Prescriber Signature*:_____Date:_____

*** Mandatory (others may not sign for prescriber). In accordance with federal law, prescribers must be enrolled in the Connecticut Medical Assistance Program (CMAP). CMAP will not pay for prescriptions written by a non-enrolled provider.**