STATE OF CONNECTICUT DEPARTMENT OF SOCIAL SERVICES TELEPHONE:
TELEPHONE: 1-866-409-8386 FAX: 1-866-759-4110

Cytokine and CAM – Interleukin-17 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:
PREFERRED IL12/IL23 AGENTS (listed for reference): PYZCHIVA SYRINGE, SUBCUTANEOUS VIAL* SELARSDI SYRINGE, VIAL* 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	BIMZELX AUTOINJECTOR, SYRINGE COSENTYX SENSOREADY PEN, SYRINGE TALTZ AUTOINJECTOR, SYRINGE

* Ustekinumab biosimilar

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 or any other specialist familiar with the treated disease state (or as appropriate for diagnosis)?	□ Yes □ No

○ Please Specify:_____	
2. Is patient using in combination with another targeted immunomodulator? ○ Please specify alternate agent:_____	□ Yes □ No
3. Does patient have active TB, or other active infection prior to initiation? ○ Please specify infection:_____	□ Yes □ No
4. **For diagnosis of Active Ankylosing Spondylitis (AS), Moderate to Severe Hidradenitis Suppurativa (HS) or Active Non-radiographic Axial Spondyloarthritis (nr-axSpA):** Patient has trialed and failed **ONE** tumor necrosis factor inhibitor (TNFi) for a minimum of 30 days **OR** documented adverse event/adverse drug reaction or contraindication ▪ Preferred agent trialed: _____ ▪ Trial Dates: _____ ▪ Reason for Contraindication or Failure: _____	□ Yes □ No □ N/A
5. **For diagnosis of Psoriatic Arthritis (PsA) or Moderate to Severe Plaque Psoriasis (PSO):** Patient has trialed and failed **ONE** tumor necrosis factor inhibitor (TNFi) **OR** preferred ustekinumab biosimilar for a minimum of 30 days **OR** documented adverse event/adverse drug reaction or contraindication ▪ Preferred agent trialed: _____ ▪ Trial Dates: _____ ▪ Reason for Contraindication or Failure: _____	□ Yes □ No □ N/A

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

(attach supporting documentation, **required**)

Bimzelx (bimekizumab-bkzx): • Patient has a documented diagnosis of ONE of the following: ○ Active Ankylosing Spondylitis (AS) (18+ years of age) ○ Moderate to Severe Hidradenitis Suppurativa (HS) (18+ years of age) ○ Active Non-radiographic Axial Spondyloarthritis (nr-axSpA) (18+ years of age) ○ Active Psoriatic Arthritis (PsA) (18+ years of age) ○ Moderate to Severe Plaque Psoriasis (PSO) (18+ years of age) 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	□ Yes □ No

agent appropriate for the specified indication (as outlined above in Questions 4 and 5 of the Clinical Information section) **AND** • For Active Non-radiographic Axial Spondyloarthritis (nr-axSpA) Diagnosis: Supporting documentation of objective signs of inflammation (e.g. elevated C-reactive protein, evidence of sacroiliitis on MRI) are ATTACHED	
Cosentyx (secukinumab): • Patient has a documented diagnosis of Active Enthesitis-related Arthritis (ERA) (4+ years of age) **OR** • ONE of the following: ▪ Active Ankylosing Spondylitis (AS) (18+ years of age) ▪ Moderate to Severe Hidradenitis Suppurativa (HS) (18+ years of age) ▪ Active Non-radiographic Axial Spondyloarthritis (nr-axSpA) (18+ years of age) ▪ Active Psoriatic Arthritis (PsA) (2+ years of age) ▪ Moderate to Severe Plaque Psoriasis (PSO) (6+ years of age) and is a candidate for systemic therapy or phototherapy **AND** o Failure to achieve the desired therapeutic outcome following a trial of at least ONE preferred agent appropriate for the specified indication (as outlined above in Questions 4 and 5 of the Clinical Information section) **AND** o For Active Non-radiographic Axial Spondyloarthritis (nr-axSpA) Diagnosis: Supporting documentation of objective signs of inflammation (e.g. elevated C-reactive protein, evidence of sacroiliitis on MRI) are ATTACHED	□ Yes □ No
Taltz (ixekizumab): • Patient has a documented diagnosis of ONE of the following: o Active Ankylosing Spondylitis (AS) (18+ years of age) o Active Non-radiographic Axial Spondyloarthritis (nr-axSpA) (18+ years of age) o Active Psoriatic Arthritis (PsA) (18+ years of age) o Moderate to Severe Plaque Psoriasis (PSO) (6+ years of age) 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 agent appropriate for the specified indication (as outlined above in Questions 4 and 5 of the Clinical Information section) **AND**	□ Yes □ No

• For Active Non-radiographic Axial Spondyloarthritis (nr-axSpA) Diagnosis: Supporting documentation of objective signs of inflammation (e.g. elevated C-reactive protein, evidence of sacroiliitis on MRI) are ATTACHED	

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

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.**