

**Cytokine and CAM – Tumor Necrosis Factor Inhibitor Agents
 Prior Authorization (PA) Request Form
 CT Medical Assistance Program
To Be Completed By Prescriber**

<u>Prescriber Information</u>	<u>Patient Information</u>
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:
<u>Prescription Information</u>	
Drug, Strength, and Dosage Form Requested:	Frequency of Dosing:
<input type="checkbox"/> New therapy <input type="checkbox"/> Continuation	Quantity Requested:

<u>Preferred Agents:</u>	<u>Non-Preferred Agents:</u>	
ADALIMUMAB-ADAZ PEN, SYRINGE*	ABRILADA PEN, SYRINGE*	IDACIO PEN SYRINGE*
ENBREL DISP SYRINGE, KIT, PEN	ADALIMUMAB-AACF*	INFLECTRA VIAL†
ENBREL MINI CARTRIDGE, VIAL	ADALIMUMAB-AATY*	REMICADE VIAL†
HADLIMA PUSHTOUCH, SYRINGE	ADALIMUMAB-ADBМ*	RENFLEXIS VIAL†
HUMIRA KIT, PEN INJECTION KIT	ADALIMUMAB-FKJP*	SIMLANDI AUTOINJECT, PEN*
INFLIXIMAB VIAL†	ADALIMUMAB-RYVK*	SIMPONI PEN, SYRINGE
	AMJEVITA AUTOINJECT, SYRINGE*	SIMPONI ARIA VIAL
	AVASOLA VIAL†	YUFLYMA PEN, SYRINGE*
	CIMZIA SYRINGE, VIAL	YUSIMRY PEN*
	CYLTEZO PEN, SYRINGE*	ZYFENTRA PEN, SYRINGE†
	HULIO PEN, SYRINGE*	
	HYRIMOZ PEN, SYRINGE*	

*Adalimumab or Adalimumab biosimilar

†Infliximab or Infliximab 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 specialist familiar with the treated disease state (or as appropriate for diagnosis)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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<ul style="list-style-type: none"> ○ Please Specify: _____ 	
<p>2. Is patient using in combination with another targeted immunomodulator?</p> <ul style="list-style-type: none"> ○ Please specify alternate agent: _____ 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>3. Does patient have active TB, or other active infection prior to initiation?</p> <ul style="list-style-type: none"> ○ Please specify infection: _____ 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>4. Patient has trialed and failed a preferred Tumor Necrosis Factor Inhibitor (TNFi) agent OR documented adverse event/adverse drug reaction or contraindication</p> <ul style="list-style-type: none"> ▪ Preferred agent trialed: _____ ▪ Trial Dates: _____ ▪ Reason for Contraindication or Failure: _____ ○ Must provide documented medical reason (e.g. allergy, contraindication, drug interaction, history of intolerance or adverse event, preferred drug is not approved for patient age/weight/indication) patient cannot utilize a preferred agent: _____ 	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A

For Initial Approval:

Medication Requested and Documented diagnosis of ONE of the following:

(attach supporting documentation, required)

<p><u>For Non-Preferred Adalimumab products:</u></p> <ul style="list-style-type: none"> - Abrilada (adalimumab-afzb) - Adalimumab-aacf - Adalimumab-aaty - Adalimumab-adbm - Adalimumab-fkjp - Adalimumab-ryvk - Amjevita (adalimumab-atto) - Cyltezo (adalimumab-adbm) - Hulio (adalimumab-fkjp) - Hyrimoz (adalimumab-adaz) - Idacio (adalimumab-aacf) - Simlandi (adalimumab-ryvk) - Yuflyma (Adalimumab-aaty) - Yusimry (Adalimumab-aqvh) <ul style="list-style-type: none"> • Patient has a documented diagnosis of ONE of the following and meets FDA approved age restriction for the requested product: <ul style="list-style-type: none"> ○ Ankylosing Spondylitis (AS) (18+ years of age) ○ Crohn's Disease (CD) (6+ years of age) 	<input type="checkbox"/> Yes <input type="checkbox"/> No
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<ul style="list-style-type: none"> ○ Hidradenitis Suppurativa (HS) (Approved age varies by product) ○ Juvenile Idiopathic Arthritis (JIA) (2+ years of age) ○ Psoriatic Arthritis (PsA) (18+ years of age) ○ Plaque Psoriasis (PsO) (18+ years of age) ○ Rheumatoid Arthritis (RA) (18+ years of age) ○ Ulcerative Colitis (UC) (18+ years of age) ○ Uveitis (UA) (Approved age varies by product) <ul style="list-style-type: none"> ● Failure to achieve the desired therapeutic outcome following a trial of a PREFERRED adalimumab agent (as outlined above in Questions 4 of the Clinical Information section) 	
<p><u>For Non-Preferred Infliximab products‡:</u></p> <ul style="list-style-type: none"> - Avsola (Infliximab-aaxq) - Inflectra (Infliximab-dyyb) - Remicade (Infliximab) - Renflexis (Infliximab-abda) <ul style="list-style-type: none"> ● Patient has a documented diagnosis of ONE of the following: <ul style="list-style-type: none"> ○ Ankylosing Spondylitis (AS) (18+ years of age) ○ Crohn’s Disease (CD) (6+ years of age) ○ Psoriatic Arthritis (PsA) (18+ years of age) ○ Plaque Psoriasis (PsO) (18+ years of age) ○ Rheumatoid Arthritis (RA) (18+ years of age) ○ Ulcerative Colitis (UC) (6+ years of age) <p>Failure to achieve the desired therapeutic outcome following a trial of a PREFERRED infliximab agent (as outlined above in Questions 4 of the Clinical Information section)</p> <p><i>‡Note: Zymfentra (infliximab-dyyb) criteria below</i></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p><u>Cimzia (Certolizumab pegol):</u></p> <ul style="list-style-type: none"> ● Patient has a documented diagnosis of ONE of the following: <ul style="list-style-type: none"> ○ Ankylosing Spondylitis (AS) (18+ years of age) ○ Crohn’s Disease (CD) (18+ years of age) 	<input type="checkbox"/> Yes <input type="checkbox"/> No

<ul style="list-style-type: none"> ○ Non-Radiographic Axial Spondyloarthritis (nr-axSpA) (18+ years of age) ○ Polyarticular Juvenile Idiopathic Arthritis (pJIA) (2+ years of age) ○ Psoriatic Arthritis (PsA) (18+ years of age) ○ Plaque Psoriasis (PsO) (18+ years of age) ○ Rheumatoid Arthritis (RA) (18+ years of age) ○ Ulcerative Colitis (UC) (18+ years of age) ● Failure to achieve the desired therapeutic outcome following a trial of a PREFERRED agent (as outlined above in Questions 4 of the Clinical Information section) AND/OR has a documented medical reason the patient cannot use a preferred product 	
<p><u>Simponi (golimumab):</u></p> <ul style="list-style-type: none"> ● Patient has a documented diagnosis of ONE of the following: <ul style="list-style-type: none"> ○ Ankylosing Spondylitis (AS) (18+ years of age) ○ Psoriatic Arthritis (PsA) (18+ years of age) ○ Rheumatoid Arthritis (RA) (18+ years of age) ○ Ulcerative Colitis (UC) (Adults and Pediatric patients weighing at least 15 kg) ● Failure to achieve the desired therapeutic outcome following a trial of a PREFERRED agent (as outlined above in Questions 4 of the Clinical Information section) AND/OR has a documented medical reason the patient cannot use a preferred product 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p><u>Simponi Aria (golimumab):</u></p> <ul style="list-style-type: none"> ● Patient has a documented diagnosis of ONE of the following: <ul style="list-style-type: none"> ○ Ankylosing Spondylitis (AS) (18+ years of age) ○ Polyarticular Juvenile Idiopathic Arthritis (pJIA) (2+ years of age) ○ Psoriatic Arthritis (PsA) (2+ years of age) ○ Rheumatoid Arthritis (RA) (18+ years of age) ● Failure to achieve the desired therapeutic outcome following a trial of a PREFERRED agent (as outlined above in Questions 4 of the Clinical Information section) AND/OR has a documented medical reason the patient cannot use a preferred product 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p><u>Zymfentra (infliximab-dyyb) (18+ years of age):</u></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No

<ul style="list-style-type: none"> ● Patient has a documented diagnosis of ONE of the following: <ul style="list-style-type: none"> ○ Crohn's Disease (CD) ○ Ulcerative Colitis (UC) AND ● Clinical rationale <u>must</u> be provided with medical reasoning as to why patient cannot utilize intravenous infliximab: _____ 	
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Renewal Information

(attach supporting documentation, **required**)

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

<ul style="list-style-type: none"> ● Has the patient previously met the required criteria set forth in Initial Approval Section above? <ul style="list-style-type: none"> ○ Previous Approved Prior Authorization Number: _____ ○ Approval Dates: _____ 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<ul style="list-style-type: none"> ● Patients' clinical response to treatment and ongoing safety has been documented and monitored 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<ul style="list-style-type: none"> ● Prescriber attests that the patient has a continued need for therapy and is compliant with current regimen 	<input type="checkbox"/> Yes <input type="checkbox"/> No
<ul style="list-style-type: none"> ● Provider has completed the Clinical Information and Initial Approval sections above for ALL Non-Preferred adalimumab formulations <p><i>NOTE: Initial therapy requirements apply to both new starts and continued therapy requests for non-preferred adalimumab formulations</i></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
<ul style="list-style-type: none"> ● Provider has completed the Clinical Information and Initial Approval sections above for ALL Non-Preferred infliximab formulations <p><i>NOTE: Initial therapy requirements apply to both new starts and continued therapy requests for non-preferred infliximab formulations</i></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A

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.**

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