



PRIOR AUTHORIZATION REQUEST

RHAPSIDO

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number:	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength:	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for ALL PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Is this request for INITIAL or CONTINUATION of therapy?		
	<input type="checkbox"/> Initial (If checked, go to 8)		
	<input type="checkbox"/> Continuation (If checked, go to 2)		
2	Will the requested medication be used in combination with a biologic or with a targeted synthetic disease-modifying antirheumatic drug (DMARD) used for an inflammatory condition?	Yes	No

**If you have any questions, call:
1-888-258-8250**

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[Note: Biologic disease-modifying antirheumatic drugs (DMARDs) include Actemra (intravenous [IV] or subcutaneous [SC]), Kevzara, Cosentyx, Kineret, Orencia (intravenous [IV] or subcutaneous [SC]), a rituximab product (for example, Rituxan, Truxima), Cimzia, Enbrel, Humira, an infliximab product (for example, Remicade, Inflectra, Renflexis), Simponi (Aria or subcutaneous [SC]), Ilumya, Siliq, Stelara (intravenous [IV] or subcutaneous [SC]), or Taltz and targeted synthetic disease-modifying antirheumatic drugs (DMARDs) include: Xeljanz/extended release (XR), Olumiant, Rinvoq, or Otezla.]
 [If yes, no further questions.]

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|----|---|-----|----|
| 3 | Is the patient currently receiving the requested medication?
[If no, skip to question 8.] | Yes | No |
| 4 | Has the patient been receiving medication samples for the requested medication?
[If yes, skip to question 8.] | Yes | No |
| 5 | Does the patient have a previously approved prior authorization (PA) on file with the current plan?
[Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.]
[If no, skip to question 8.] | Yes | No |
| 6 | Has the patient been established on therapy for at least 3 months?
[If no, skip to question 8.] | Yes | No |
| 7 | Has documentation been submitted to confirm that the patient has had a clinically significant response to therapy, as determined by the prescriber? ACTION REQUIRED: Submit supporting documentation.
[Note: Examples of a beneficial response include decreased itch severity; decreased number of hives; decreased size of hives.]
[No further questions.] | Yes | No |
| 8 | What is the diagnosis or indication?
<input type="checkbox"/> Chronic spontaneous urticaria (If checked, go to 9)

<input type="checkbox"/> Other (If checked, no further questions) | | |
| 9 | Is the patient 18 years of age or older?
[If no, no further questions.] | Yes | No |
| 10 | Will the requested medication be used in combination with a biologic or with a targeted synthetic disease-modifying antirheumatic drug (DMARD) used for an inflammatory condition?
[Note: Biologic disease-modifying antirheumatic drugs (DMARDs) include Actemra (intravenous [IV] or subcutaneous [SC]), Kevzara, Cosentyx, Kineret, Orencia (intravenous [IV] or subcutaneous [SC]), a rituximab product (for example, Rituxan, Truxima), Cimzia, Enbrel, Humira, an infliximab product (for example, | Yes | No |

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Remicade, Inflectra, Renflexis), Simponi (Aria or subcutaneous [SC]), Ilumya, Siliq, Stelara (intravenous [IV] or subcutaneous [SC]), or Taltz and targeted synthetic disease-modifying antirheumatic drugs (DMARDs) include: Xeljanz/extended release (XR), Olumiant, Rinvoq, or Otezla.]
 [If yes, no further questions.]

- | | | | |
|----|--|-----|----|
| 11 | Has documentation been submitted to confirm that the patient has had urticaria for 6 weeks or greater prior to treatment with the requested medication? ACTION REQUIRED: Submit supporting documentation.
[If no, no further questions.] | Yes | No |
| 12 | Has documentation been submitted to confirm that the patient has had a treatment failure with a high-dose oral second generation H1 antihistamine therapy for AT LEAST 1 month unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation.
[Note: High-dose oral second-generation H1 antihistamine therapy is the highest dose tolerated by the patient and can be up to four times the Food and Drug Administration (FDA)-approved dose. Examples of second-generation H1 antihistamines are cetirizine, fexofenadine, and loratadine.]
[If no, no further questions.] | Yes | No |
| 13 | Has documentation been submitted to confirm that the patient has had a treatment failure with an IL-4 antagonist, Dupixent, for AT LEAST 3 months unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation.
[If no, no further questions.] | Yes | No |
| 14 | Has documentation been submitted to confirm that the patient has had a treatment failure with Xolair for AT LEAST 3 months unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation.
[If no, no further questions.] | Yes | No |
| 15 | Is this medication being prescribed by, or in consultation with an allergist, immunologist, or dermatologist?
[If no, no further questions.] | Yes | No |
| 16 | Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication?
[Note: Dosing: 25 mg twice daily (BID).] | Yes | No |

Please document the diagnoses, symptoms, and/or any other information important to this review:

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SECTION B: Physician Signature

PHYSICIAN SIGNATURE

DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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