

PRIOR AUTHORIZATION REQUEST

etanercept SC product (for example, Enbrel, biosimilars), Ilumya, Skyrizi, Kevzara, Kineret, Orencia (IV or SC), an infliximab IV products (Remicade, biosimilars), a rituximab IV products (for example, Rituxan, biosimilars), Siliq, Stelara (IV or SC), Taltz, Tremfya, Entyvio, or Simponi (Aria or SC).]
 [If yes, no further questions.]

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| 3 | Is the patient currently receiving Actemra subcutaneous?
[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 provider? ACTION REQUIRED: Submit supporting documentation.
[No further questions.] | Yes | No |
| 8 | Will the requested medication be used in combination with other biologics?
[Note: Examples of biologics include but not limited to adalimumab SC products (for example, Humira, biosimilars), Actemra (IV or SC), Cimzia, Cosentyx, an etanercept SC product (for example, Enbrel, biosimilars), Ilumya, Skyrizi, Kevzara, Kineret, Orencia (IV or SC), an infliximab IV products (Remicade, biosimilars), a rituximab IV products (for example, Rituxan, biosimilars), Siliq, Stelara (IV or SC), Taltz, Tremfya, Entyvio, or Simponi (Aria or SC).]
[If yes, no further questions.] | Yes | No |
| 9 | What is the diagnosis or indication?
<input type="checkbox"/> Giant cell arteritis (If checked, go to 10)

<input type="checkbox"/> Interstitial lung disease associated with systemic sclerosis (If checked, go to 16)

<input type="checkbox"/> Polyarticular juvenile idiopathic arthritis (PJIA) (If checked, go to 26)

<input type="checkbox"/> Rheumatoid arthritis (If checked, go to 34)

<input type="checkbox"/> Systemic juvenile idiopathic arthritis (SJIA) (If checked, go to 41)

<input type="checkbox"/> Polymyalgia rheumatica (PMR) (If checked, go to 48) | | |

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COVID-19 (Coronavirus Disease 2019) (If checked, no further questions)

Crohn's disease (If checked, no further questions)

Other (If checked, no further questions)

10	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
11	Has the patient tried at least one systemic corticosteroid for at least 3 months? [Note: An example of a systemic corticosteroid is prednisone.] [If yes, skip to question 13.]	Yes	No
12	Has documentation been provided to confirm that the patient had an intolerance to at least one systemic corticosteroid? ACTION REQUIRED: Submit supporting documentation. [Note: An example of a systemic corticosteroid is prednisone.] [If no, no further questions.]	Yes	No
13	Does the patient have relapsing Giant cell arteritis (GCA)? [If no, no further questions.]	Yes	No
14	Is this medication being prescribed by or in consultation with a rheumatologist? [If no, no further questions.]	Yes	No
15	Does the requested dose exceed Food and Drug Administration (FDA) approved label dosing for the requested indication? Note: Dosing is 162mg subq injection once weekly. [No further questions.]	Yes	No
16	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
17	Does the patient have elevated acute phase reactants, defined as C-reactive protein (CRP) greater than or equal to 6 mg/mL? [If yes, skip to question 19.]	Yes	No
18	Does the patient have elevated acute phase reactants, defined as erythrocyte sedimentation rate (ESR) greater than or equal 28 mm/h? [If no, no further questions .]	Yes	No
19	Does the patient have elevated acute phase reactants, defined as platelet count greater than or equal 330 x 10 ⁹ /L? [If no, no further questions.]	Yes	No
20	Does the patient have a forced vital capacity (FVC) that is greater than 55% of the predicted value? [If no, no further questions.]	Yes	No

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21	Is the patient's diagnosis confirmed by high-resolution computed tomography? [If no, no further questions.]	Yes	No
22	Has the patient tried at least one other agent for this condition for at least 3 months? [Note: Examples of other agents tried includes mycophenolate, azathioprine.] [If yes, skip to question 24.]	Yes	No
23	Has documentation been provided to confirm that the patient had an intolerance to at least two other agents? ACTION REQUIRED: Submit supporting documentation. [Note: Examples of other agents tried includes mycophenolate, azathioprine.] [If no, no further questions.]	Yes	No
24	Is this medication being prescribed by or in consultation with a pulmonologist or rheumatologist? [If no, no further questions.]	Yes	No
25	Does the requested dose exceed Food and Drug Administration (FDA) approved label dosing for the requested indication? Note: Dosing is 162mg subq injection once weekly. [No further questions.]	Yes	No
26	Is the patient greater than or equal to 2 years of age? [If no, no further questions.]	Yes	No
27	Has the patient tried at least one other prescription strength agent for this condition for at least 3 months? [Note: Examples of other agents tried includes methotrexate (MTX), sulfasalazine, leflunomide, or a prescription strength nonsteroidal anti-inflammatory drug (NSAID).] [If yes, skip to question 29.]	Yes	No
28	Has documentation been provided to confirm that the patient had an intolerance to at least two other agents? ACTION REQUIRED: Submit supporting documentation. [Note: Examples of other agents tried includes methotrexate (MTX), sulfasalazine, leflunomide, or a prescription strength nonsteroidal anti-inflammatory drug (NSAID).] [If no, no further questions.]	Yes	No
29	Does the patient have aggressive disease, as determined by the prescriber? [If no, no further questions.]	Yes	No
30	Has documentation been provided to confirm that the patient had an intolerance, contraindication to, or failed treatment for at least 3 months with the preferred TNF inhibitor, an adalimumab product (Hadlima, Yusimry, or adalimumab- adbm)? ACTION REQUIRED: Submit supporting documentation.	Yes	No

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[If no, no further questions.]

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| 31 | Has documentation been provided to confirm that the patient had an intolerance, contraindication to, or failed treatment for at least 3 months with preferred JAK inhibitor, Xeljanz? ACTION REQUIRED: Submit supporting documentation.
[If no, no further questions.] | Yes | No |
| 32 | Is this medication being prescribed by or in consultation with a rheumatologist?
[If no, no further questions.] | Yes | No |
| 33 | Does the requested dose exceed Food and Drug Administration (FDA) approved label dosing for the requested indication? Note: Dosing is, for patients greater than or equal to 30kg - 162mg subq injection once every 2 weeks and patients less than 30kg - 162mg subq injection once every 3 weeks.
[No further questions.] | Yes | No |
| 34 | Is the patient greater than or equal to 18 years of age?
[If no, no further questions.] | Yes | No |
| 35 | Has the patient tried at least one conventional synthetic disease-modifying antirheumatic drug (DMARD) for at least 3 months?
[Note: Examples of conventional synthetic DMARDs include methotrexate (oral or injectable), leflunomide, hydroxychloroquine, and sulfasalazine.]
[If yes, skip to question 37.] | Yes | No |
| 36 | Has documentation been provided to confirm that the patient had an intolerance to at least two conventional synthetic DMARDs? ACTION REQUIRED: Submit supporting documentation.
[Note: Examples of conventional synthetic DMARDs include methotrexate (oral or injectable), leflunomide, hydroxychloroquine, and sulfasalazine.]
[If no, no further questions.] | Yes | No |
| 37 | Has documentation been provided to confirm that the patient had an intolerance, contraindication to, or failed treatment for at least 3 months with the preferred TNF inhibitor, an adalimumab product (Hadlima, Yusimry, or adalimumab- adbm)? ACTION REQUIRED: Submit supporting documentation.
[If no, no further questions.] | Yes | No |
| 38 | Has documentation been provided to confirm that the patient had an intolerance, contraindication to, or failed treatment for at least 3 months with preferred JAK inhibitor, Xeljanz? ACTION REQUIRED: Submit supporting documentation.
[If no, no further questions.] | Yes | No |
| 39 | Is this medication being prescribed by or in consultation with a rheumatologist?
[If no, no further questions.] | Yes | No |
| 40 | Does the requested dose exceed Food and Drug Administration (FDA) approved label dosing for the requested indication? Note: Dosing is 162mg subq injection | Yes | No |

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once every 2 weeks.
[No further questions.]

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| 41 | Is the patient greater than or equal to 2 years of age?
[If no, no further questions.] | Yes | No |
| 42 | Has the patient tried at least two other systemic agents for this condition for at least 3 months?
[Note: Examples of one other systemic agents tried include a corticosteroid (oral, IV), a conventional synthetic disease-modifying antirheumatic drug (DMARD) (for example, methotrexate [MTX], leflunomide, sulfasalazine).]
[If yes, skip to question 44.] | Yes | No |
| 43 | Has documentation been provided to confirm that the patient had an intolerance to at least two systemic agents? ACTION REQUIRED: Submit supporting documentation.
[Note: Examples of one other systemic agents tried include a corticosteroid (oral, IV), a conventional synthetic disease-modifying antirheumatic drug (DMARD) (for example, methotrexate [MTX], leflunomide, sulfasalazine).]
[If no, no further questions.] | Yes | No |
| 44 | Has documentation been provided to confirm that the patient had an intolerance, contraindication to, or failed treatment for at least 3 months with the preferred TNF inhibitor, an adalimumab product (Hadlima, Yusimry, or adalimumab- adbm)? ACTION REQUIRED: Submit supporting documentation.
[If no, no further questions.] | Yes | No |
| 45 | Has documentation been provided to confirm that the patient had an intolerance, contraindication to, or failed treatment for at least 3 months with the preferred JAK inhibitor, Xeljanz? ACTION REQUIRED: Submit supporting documentation.
[If no, no further questions.] | Yes | No |
| 46 | Is this medication being prescribed by or in consultation with a rheumatologist?
[If no, no further questions.] | Yes | No |
| 47 | Does the requested dose exceed Food and Drug Administration (FDA) approved label dosing for the requested indication? Note: Dosing is, for patients greater than or equal to 30kg - 162mg subq injection once every 2 weeks and patients less than 30kg -162mg subq injection once every 3 weeks.
[No further questions.] | Yes | No |
| 48 | Is the patient greater than or equal to 18 years of age?
[If no, no further questions.] | Yes | No |
| 49 | Has the patient tried at least one systemic corticosteroid for at least 3 months?
[Note: An example of a systemic corticosteroid is prednisone.]
[If yes, skip to question 51.] | Yes | No |

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50	Has documentation been provided to confirm that the patient had an intolerance to at least two systemic corticosteroids? ACTION REQUIRED: Submit supporting documentation. [Note: An example of a systemic corticosteroid is prednisone.] [If no, no further questions.]	Yes	No
51	Is this medication being prescribed by or in consultation with a rheumatologist? [If no, no further questions.]	Yes	No
52	Does the requested dose exceed Food and Drug Administration (FDA) approved label dosing for the requested indication? Note: Dosing is 162mg subq injection once every 2 weeks.	Yes	No

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

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.

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