REALRx

PRIOR AUTHORIZATION REQUEST FORM

PSORIATIC ARTHRITIS

Cimzia®, Enbrel®, Hadlima™, Humira®, Orencia®, Otezla®, Rinvoq, Simponi®, Skyrizi, Stelara®, Taltz®, Tremfya®, Xeljanz/XR®

For authorization, please answer each question and fax this form PLUS chart notes back to Real Rx at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance 385-425-5094.

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred/Non-preferred

1. Preferred First line agents:
   A. Cimzia® (certolizumab), Enbrel® (etanercept), Hadlima™ (adalimumab-bwwd), Humira® (adalimumab), Otezla® (apremilast), Rinvoq® (upadacitinib), Simponi® (golimumab), Skyrizi® (risankizumab-rzaa), Stelara® (ustekinumab), Tremfya® (guselkumab), Xeljanz/XR ® (tofacitinib)
2. Non-Preferred with a single step after trial and failure of at least one preferred first line agent with the exception of Otezla®:
   A. Taltz® (ixekizumab)
3. Non-Preferred with a double step; after trial and failure of at least two first line agents with the exception of Otezla®:
   A. Orencia® (abatacept)
4. Excluded/Non-formulary:
   A. Cosentyx® (secukinumab)

Product being requested: _____

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Is the requested medication being purchased by the provider's office and to be billed under the medical benefit ('buy-and-bill')?	☐	☐	
2. Is this request for an **expedited** review? By checking the **"Yes"** box to request an expedited review (24 hours), you are certifying that applying the standard review time frame (72 hours) may place the member's life, health, or ability to regain maximum function in serious jeopardy.	☐	☐	
3. Is the patient 18 years of age or older with active psoriatic arthritis?	☐	☐	**Please provide documentation**

4. Is the request from, or in consultation with, a rheumatologist or a dermatologist?	☐	☐	
5. Has the patient had an adequate trial and failure of at least one of the following disease-modifying antirheumatic drugs (DMARDs), unless contraindicated to all: methotrexate, leflunomide, sulfasalazine, azathioprine, intra-articular glucocorticoid injections, hydroxychloroquine, D-penicillamine, or minocycline?	☐	☐	**Please provide documentation**
6. Does the member have moderate axial disease, severe disease, or enthesitis? • For patients with moderate axial disease, severe disease, or enthesitis, a trial and failure of a DMARD may not be necessary.	☐	☐	**Please provide documentation**
7. If the request is for a Tumor Necrosis Factor Inhibitor or an Interleukin Receptor Antagonist, has the provider performed tuberculosis (TB) screening prior to therapy initiation?	☐	☐	**Please provide documentation**
8. If the request is for a Tumor Necrosis Factor Inhibitor, has the provider performed hepatitis B screening prior to therapy initiation?	☐	☐	**Please provide documentation**
9. If the request is for Xeljanz/XR or Rinvoq, does documentation show an inadequate response or intolerance to at least one TNF (tumor necrosis factor) blocker such as an infliximab product, Cimzia, Enbrel, Humira and/or Simponi AND does documentation show the member will not be receiving Xeljanz/XR or Rinvoq in combination with a potent immunosuppressant (e.g., azathioprine or cyclosporine)?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member's therapy been re-evaluated within the past 12 months?	☐	☐	
3. Has the therapy shown to be tolerable and effective with a significant decrease in disease severity?	☐	☐	**Please provide documentation**
4. Does the member show a continued medical need for the therapy?	☐	☐	**Please provide documentation**
5. Has the provider performed continued tuberculosis monitoring during therapy?	☐	☐	**Please provide documentation**
1. Has the provider performed continued Hepatitis B monitoring in HBV carriers?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			

Physician's Signature:

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Policy PHARM-062
Origination Date: 03/27/2018
Reviewed/Revised Date: 09/13/2023
Next Review Date: 09/13/2024
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