AmeriHealth Caritas™
New Hampshire

Systemic Immunomodulators Medication

Prior Authorization Drug Approval Form

Date of medication request: (MM/DD/YYYY): ____ / ____ / _____

Patient information and medication requested	
Patient's name:	Medicaid number:
Date of birth:	Gender:
Drug name:	Strength:
Dosing directions:	Length of therapy:

Prescriber information			
Prescriber last name:		Prescriber first name:	
Prescriber address:		Prescriber representative:	
Specialty:		NPI number:	
Phone #:	Fax #:		

Clinical history

1. Patient's diagnosis for use of this medication (please be complete and use a separate sheet if additional space is required):

Please respond to the following section based on diagnosis medication is being requested for below:

2. **Rheumatoid Arthritis** — Previous failure, contraindication, or adverse reaction to methotrexate AND at least one DMARD (sulfasalazine, hydroxychloroquine, minocycline) ☐ Yes ☐ No

3. **Moderate to Severely Active Crohn's Disease** — Previous failure, contraindication, or adverse reaction to oral corticosteroid. ☐ Yes ☐ No

4. **Moderate to Severely Active Ulcerative Colitis** — Previous failure, contraindication, or adverse reaction to oral/rectal aminosalicylate AND oral corticosteroid AND azathioprine or mercaptopurine for three months. ☐ Yes ☐ No

5. **Severe Chronic Plaque Psoriasis** — Previous failure, contraindication, or adverse reaction to topical psoriasis agents. ☐ Yes ☐ No

6. **Ankylosing Spondylitis** — Previous failure, contraindication, or adverse reaction to NSAIDS. ☐ Yes ☐ No

7. **Psoriatic Arthritis or Juvenile Idiopathic Arthritis** — Previous failure, contraindication, or adverse reaction to methotrexate. ☐ Yes ☐ No

8. Does the patient have a diagnosis of moderate to severe heart failure? ☐ Yes ☐ No

9. Does the patient have a diagnosis of irritable bowel syndrome? (For Cosentyx only) ☐ Yes ☐ No

10. Is the patient pregnant? (Female only) ☐ Yes ☐ No

11. Is the patient currently on another systemic immunomodulator? ☐ Yes ☐ No
If yes, list medication:

12. Is the patient HIV positive? ☐ Yes ☐ No

Provide any additional information that would help in the decision-making process. If additional space is needed, please use a separate sheet.

Non-preferred drug approval criteria

Chapter 188 of the Laws of 2004 requires that Medicaid only cover non-preferred drugs upon a finding of medical necessity by the prescribing physician. Chapter 188 requires that you base your determination of medical necessity on the following criteria.

☐ Allergic reaction ☐ Drug-to-drug reaction
Please describe reaction:

☐ Previous episode of an unacceptable side effect or therapeutic failure.
Please describe reaction:

☐ Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to a preferred drug.
Please provide clinical information:

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Non-preferred drug approval criteria
☐ Age specific indications. Please provide patient age and explain:
☐ Unique clinical indication supported by FDA approval or peer reviewed literature. Please explain and provide a reference:
☐ Unacceptable clinical risk associated with therapeutic change. Please explain:

Signature of prescriber:_____ Date: _____
(prescriber signature mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.