Anti-Inflammatory Therapy Step Therapy

Cimzia (certolizumab pegol) J0717, Omvoh (mirikizumab-mrkz) J2267, Spevigo (spesolimab-sbzo) J1747, Skyrizi (risankizumab-rzaa) J2327, Ilumya (tildrakizumab) J3245 are non-preferred. The preferred products are Simponi (Golimumab) J1602, Cosentyx IV (secukinumab IV)J3247, Stelara (Ustekinumab; SubQ and IV) J3357/J3358

Prior Authorization Request

Medicare Part B Form

*Instructions: * Indicates required information – Form may be returned if required information is not provided. Please fax this request to the appropriate fax number listed at the bottom of the page.*

☐	**Standard Request– (72 Hours)**	☐	**Urgent Request** (standard time frame could place the member's life, health or ability in serious jeopardy)
	Date Requested _____		
	Requestor _____ Clinic name: _____ Phone / Fax		

MEMBER INFORMATION

*Name:_____ *ID#:_____ *DOB:_____

PRESCRIBER INFORMATION

*Name:_____ ☐MD ☐FNP ☐DO ☐NP ☐PA *Phone:_____

*Address:_____ *Fax:_____

DISPENSING PROVIDER / ADMINISTRATION INFORMATION

*Name:_____ Phone:_____

*Address:_____ Fax:_____

PROCEDURE / PRODUCT INFORMATION

HCPC Code	Name of Drug	Dose (Wt: _____ kg Ht:_____)	Frequency	End Date if known

☐ **Self-administered** ☐ **Provider-administered** ☐ **Home Infusion**

☐Chart notes attached. **Other important information:**_____

Diagnosis: ICD10: _____ **Description**: _____

☐ Provider attests the diagnosis provided is an FDA-Approved indication for this drug

CLINICAL INFORMATION

☐ **New Start or Initial Request: (Clinical documentation required for all requests)**

☐ Rheumatoid Arthritis

Preferred: ☐ Simponi

Non-Preferred: ☐ Humira ☐ Cimzia **(Must try/fail Preferred alternative)**

☐ Juvenile Idiopathic Arthritis

Preferred: ☐ Simponi

Non-Preferred: ☐ Humira ☐ Cosentyx **(Must try/fail Preferred alternative)**

☐ Ankylosing Spondylitis

Preferred: ☐ Simponi

Non-Preferred: ☐ Humira ☐ Cosentyx ☐ Cimzia **(Must try/fail Preferred alternative)**

☐ Psoriatic Arthritis

Preferred: ☐ Simponi ☐ Skyrizi

Non-Preferred ☐ Humira ☐ Cimzia ☐ Stelara ☐ Cosentyx

(Must try/fail Preferred alternative)

☐ Plaque Psoriasis

Preferred: ☐ Ilumya

Non-Preferred: ☐ Humira ☐ Cimzia ☐ Stelara ☐ Cosentyx ☐ Skyrizi

(Must try/fail Preferred alternative)

☐ Hidradenitis Suppurativa

Preferred: ☐ Humira

Non-Preferred: ☐ Cosentyx **(Must try/fail Preferred alternative)**

☐ Crohn's Disease

Preferred: ☐ Stelara IV ☐ Cimzia

Non-Preferred: ☐ Humira ☐ Stelara SC ☐ Skyrizi **(Must try/fail Preferred alternative)**

☐ Ulcerative Colitis

Preferred: ☐ Simponi

Non-Preferred: ☐ Humira ☐ Stelara ☐ Omvoh ☐ Skyrizi

(**Must try/fail Preferred alternative)**

☐ Uveitis

☐ Humira

☐ Non-radiographic axial spondyloarthritis

Preferred: ☐ Cimzia

Non-Preferred: ☐ Cosentyx **(Must try/fail Preferred alternative)**

☐ Generalized Pustular Psoriasis

☐ Spevigo

☐ **Provider has reviewed the attached "Criteria for Approval" and attests the member meets ALL required PA criteria.**

If not, please provide **clinical rationale** for formulary exception: _____

_____

☐ Continuation Requests: (Clinical documentation required for all requests)

☐ **Provider has reviewed the attached "Criteria for Continuation" and attests the member meets ALL required PA Continuation criteria.**

☐ Patient had an adequate response or significant improvement while on this medication.

If not, please provide clinical rationale for continuing this medication: _____

_____

ACKNOWLEDGEMENT

Request By (Signature Required): _____Date:_____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. THIS AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT. PAYMENT IS BASED ON BENEFITS IN EFFECT AT THE TIME OF SERVICE, MEMBER ELIGIBILITY AND MEDICAL NECESSITY.

Prior Authorization Group – Anti-Inflammatory Therapy PA

Drug Name(s):

CIMZIA	**CERTOLIZUMAB PEGOL**
SIMPONI	**GOLIMUMAB**
ILUMYA	**TILDRAKIZUMAB-ASMN**
STELARA	**USTEKINUMAB**
SKYRIZI	**RISANKIZUMAB-RZAA**
SPEVIGO	**SPESOLIMAB-SBZO**
COSENTYX IV	**SECUKINUMAB IV**
OMVOH	**MIRIKIZUMAB-MRKZ**

Criteria for approval of Prior Authorization Drug:

1. Prescribed for an approved FDA diagnosis (as listed below):
2. Member has tried and failed at least ONE of the formulary alternatives:**Simponi or Stelara** OR
   - There is clinical documentation stating formulary alternatives are contraindicated.
3. Member does not have any clinically relevant contraindications, or CMS/Plan exclusions, to the requested drug.

- If the member meets all these criteria, they may be approved by the Plan for the requested drug.
- Quantity limits and Tiering will be determined by the Plan.

Exclusion Criteria:

N/A

Prescriber Restrictions:

N/A

Coverage Duration:

Approval will be for 12 months

FDA Indications:

Cimzia

- Ankylosing spondylitis, Active
- Crohn's disease, Active, moderate to severe
- Non-radiographic axial spondyloarthritis
- Plaque psoriasis, Moderate to severe
- Psoriatic arthritis, Active
- Rheumatoid arthritis, Active, moderate to severe

Cosentyx

- Ankylosing spondylitis, Active
- Hidradenitis suppurativa (Moderate to Severe)
- Juvenile idiopathic arthritis, Active, enthesitis-related
- Non-radiographic axial spondyloarthritis, Active; with objective signs of inflammation
- Plaque psoriasis (Moderate to Severe), In patients who are candidates for systemic therapy or phototherapy
- Psoriatic arthritis, Active

Ilumya

- Plaque psoriasis (Moderate to Severe), In candidates for systemic therapy or phototherapy

Simponi
- Ankylosing spondylitis, Active
- Polyarticular juvenile idiopathic arthritis, Active
- Psoriatic arthritis, Active
- Rheumatoid arthritis (Moderate to Severe), Active, in combination with methotrexate
- Ulcerative colitis (Moderate to Severe), Active
- Rheumatoid arthritis

Spevigo
- Crohn's disease, Moderately to Severely Active
- Plaque psoriasis (Moderate to Severe), Eligible for systemic therapy or phototherapy
- Psoriatic arthritis, Active

Stelara
- Crohn's disease (Moderate to Severe), Failed or intolerant to a tumor necrosis factor antagonist
- Crohn's disease (Moderate to Severe), Failed or intolerant to immunomodulators or corticosteroids
- Plaque psoriasis (Moderate to Severe)
- Psoriatic arthritis, Active, alone or in combination with methotrexate
- Ulcerative colitis (Moderate to Severe), Active

Spevigo
- Generalized pustular psoriasis, Flares

Omvoh
- Ulcerative colitis (Moderate to Severe)

Off-Label Uses:
Stelara
- Rheumatoid arthritis

Age Restrictions:
N/A

Other Clinical Considerations:
N/A

Resources:
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