mercy care

Fax completed prior authorization request form to 800-854-7614 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at www.mercycareaz.org/providers/completecare-forproviders/pharmacy

Cytokines and Cell Adhesion Molecule (CAM) Antagonists Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification are required to support diagnosis

Member Information						
Member Name (first & last):	Date of Birth:	Gender: ☐ Male ☐ Female				Height:
Member ID:	City:	State:				Weight:
Prescribing Provider Information						
Provider Name (first & last):	Specialty:	NPI#				DEA#
Office Address:	City:	State:				Zip Code:
Office Contact:	Office Phone					Office Fax:
Dispensing Pharmacy Information						
Pharmacy Name:	Pharmacy Phone:					Pharmacy Fax:
Requested Medication Information						
Preferred Agents:	☐ Enbrel	☐ Humira	☐ Otezla	☐ Xeljanz IR		
Non-Preferred Agents:	☐ Actemra	☐ Arcalyst	☐ Cosentyx	☐ Taltz	☐ Ilaris	☐ Ilumya
	☐ Kineret	☐ Siliq	☐ Orencia	☐ Renflexis	☐ Tremfya	☐ Tysabri
	☐ Olumiant	☐ Remicade	☐ Xeljanz XR	☐ Cimzia	☐ Skyrizi	☐ Simponi Aria
	☐ Simponi	☐ Stelara	☐ Inflectra	☐ Other, specify:		
Medication request is NOT for an FDA- approved, or compendia-supported diagnosis (circle one): Yes No	Diagnosis:					☐ ICD-10 Code:
Are there any contraindications to formulary medications? (if yes, specify):	☐ Yes	☐ No	☐ New request	☐ Continuation of therapy		
Directions for Use:	Strength:					Dosage Form:
	Quantity:	Day Supply:				Duration of Therapy/Use:
What medication(s) has the member tried and failed for this diagnosis? Please specify below.						
Turn-Around Time for Review						
☐ Standard – (24 hours)	☐ **Urgent** – waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: _____					
Clinical Information						
General Authorization Criteria						
Is member on another Cytokine or Cell Adhesion Molecule (CAM) Antagonist?				☐ Yes	☐ No	
Is request for Anti-Tumor Necrosis Factor?	☐ Yes	☐ No	Does member have NYHA class III OR IV CHF?	☐ Yes	☐ No	☐ N/A
Is request for Anti-Tumor Necrosis Factors such as Stelara, Xeljanz, Xeljanz XR, Kineret, Actemra, Ilaris OR Orencia?				☐ Yes	☐ No	
Was a screen completed for Hepatitis B?	☐ Yes	☐ No	Does member have active OR chronic Hepatitis B?	☐ Yes	☐ No	
If member has active OR chronic Hepatitis B, is member receiving appropriate antiviral treatment?				☐ Yes	☐ No	☐ N/A
Was member evaluated AND given appropriate vaccinations, as recommended per CDC, for risk factors?				☐ Yes	☐ No	

Was member screened for TB?	☐ Yes	☐ No	If screening was positive for latent TB, was treatment received for latent TB?	☐ Yes	☐ No	☐ N/A		
Is request for Entyvio OR Tysabri?	☐ Yes	☐ No	Is use Monotherapy AND not in combination with antineoplastic, immunosuppressive OR immunomodulating agents (AZA, 6-MP, cyclosporine, MTX, TNF inhibitors)	☐ Yes	☐ No	☐ N/A		

Additional Criteria Based on Indication:

☐ Rheumatoid Arthritis

Was there inadequate response to 3-month trial of MTX?	☐ Yes	☐ No	Was there intolerance OR contraindication to MTX?	☐ Yes	☐ No
Were SSZ, LEF or HCQ used due to intolerance OR contraindication to MTX?	☐ Yes	☐ No	Will requested medication be used concurrently with MTX or another non-biologic DMARD such as SSZ, LEF or HCQ?	☐ Yes	☐ No

☐ Systemic Juvenile Idiopathic Arthritis

Does member have ACTIVE SYSTEMIC FEATURES such as fever, evanescent rash, lymphadenopathy, hepatomegaly, splenomegaly OR serositis? (circle one): ☐ Yes ☐ No	Is synovitis in ONE OR MORE JOINTS despite 3 months treatment with MTX OR LEF? (circle one): ☐ Yes ☐ No
Check if ONE of the following apply:	☐ There are ACTIVE SYSTEMIC FEATURES (fever, evanescent rash, lymphadenopathy, hepatomegaly, splenomegaly OR serositis) AND synovitis is in at least ONE JOINT.
	☐ There are NO ACTIVE SYSTEMIC FEATURES (fever, evanescent rash, lymphadenopathy, hepatomegaly, splenomegaly OR serositis) AND synovitis is in ONE OR MORE JOINTS despite 3 months treatment with MTX OR LEF.
There are ACTIVE SYSTEMIC FEATURES (fever, evanescent rash, lymphadenopathy, hepatomegaly, splenomegaly, or serositis) (circle one): ☐ Yes ☐ No	Synovitis is in ONE OR MORE JOINTS despite ONE-month treatment with Kineret OR Actemra AND MTX OR LEF (circle one): ☐ Yes ☐ No

☐ Polyarticular Juvenile Idiopathic Arthritis

Was there inadequate response to 3-months trial with MTX?	☐ Yes	☐ No	Was there an intolerance OR contraindication to MTX?	☐ Yes	☐ No	☐ N/A
Was there trial with SSZ OR LEF for 3 months?	☐ Yes	☐ No	☐ N/A			

☐ Oligoarticular Juvenile Idiopathic Arthritis

Is disease duration > 6 months?	☐ Yes	☐ No	Was there documented inadequate response OR intolerable side effect with 2 NSAIDs?	☐ Yes, indicate drug:			☐ No	
Was there contraindication to NSAIDs?	☐ Yes	☐ No	☐ N/A	Was there inadequate response OR intolerable side effect to 3-month trial with MTX?		☐ Yes	☐ No	
Was there documented trial of LEF OR SSZ for 3 months?	☐ Yes	☐ No	☐ N/A					

☐ Cryopyrin-Associated Periodic Syndromes

Indicate if ONE of the following subtypes is present:	☐ Familial Cold Auto Inflammatory Syndrome	☐ Muckle-Wells syndrome	☐ Neonatal onset multi-system inflammatory disease
Was there 3-months trial with Kineret?	☐ Yes	☐ No	☐ N/A

☐ Familial Mediterranean Fever

Was there inadequate response, intolerance OR contraindication to colchicine at MAX indicated dose?	☐ Yes	☐ No

☐ Giant Cell Arteritis

Was there inadequate response with glucocorticoids (prednisone, methylprednisolone)?	☐ Yes	☐ No	Was there intolerance OR contraindication to glucocorticoids?			☐ Yes	☐ No
If member had intolerance OR contraindication to glucocorticoids, was there TRIAL with MTX OR cyclophosphamide?	☐ Yes	☐ No	☐ N/A	Will medication be used in combination with tapering course of glucocorticoids		☐ Yes	☐ No

☐ Ankylosing Spondylitis

Was there inadequate response to ONE-month trial of TWO NSAIDs?	☐ Yes	☐ No	Is there contraindication OR intolerance to oral NSAIDs?	☐ Yes	☐ No	☐ N/A

☐ Psoriatic Arthritis

Does member have ACTIVE Psoriatic Arthritis?	☐ Yes	☐ No	Was there inadequate response to 3-months trial with MTX?			☐ Yes	☐ No
Was there intolerance OR contraindication to MTX?	☐ Yes	☐ No	☐ N/A	Was there 3-month trial of SSZ OR LEF?		☐ Yes	☐ No
Is disease predominantly AXIAL OR ACTIVE ENTHESITIS / DACTYLITIS?					☐ Yes	☐ No	
Was there inadequate response to ONE-month trial of 2 NSAIDs?	☐ Yes	☐ No	Was there contraindication OR intolerance to oral NSAIDs?		☐ Yes	☐ No	☐ N/A

☐ Plaque Psoriasis

Was there inadequate response to MTX OR cyclosporine for ≥3 months?	☐ Yes	☐ No	Was there intolerance OR contraindication to MTX OR cyclosporine for ≥3 months?	☐ Yes	☐ No	☐ N/A
Is >10% BSA affected?	☐ Yes	☐ No	Is <10% BSA affected BUT involves sensitive areas such as hands, feet, face OR genitals?	☐ Yes	☐ No	

Is Psoriasis Area and Severity Index score >10?	☐ Yes	☐ No	Was phototherapy PUVA, UVB ineffective?	☐ Yes	☐ No		
For Siliq ONLY:	Is there history of a prior suicide attempt, bipolar disorder OR depressive disorder?			☐ Yes	☐ No		
	Was a mental health evaluation completed by prescriber OR psychiatrist?			☐ Yes	☐ No		

☐ Ulcerative Colitis		
☐ STEROID DEPENDENT	A relapse occurred within 3-months of stopping glucocorticoids (circle one): ☐ Yes ☐ No	There is Inability to taper steroids to acceptable dose after 3 months W/O having symptom recurrence:(circle one): ☐ Yes ☐ No
☐ STEROID REFRACTORY	Inadequate response OR intolerable side effect to IV glucocorticoids after 7-10 days (circle one): ☐ Yes ☐ No	Inadequate response OR intolerable side effect to oral prednisone ≥40mg per day after 30 days (circle one): ☐ Yes ☐ No
☐ Crohn's Disease		
☐ STEROID DEPENDENT	A relapse occurred within 3-months of stopping glucocorticoids (circle one): ☐ Yes ☐ No	There was inadequate response OR intolerable side effect, with 3-month trial of 6-MP OR AZA OR injectable MTX (circle one): ☐ Yes ☐ No
	There is inability to taper steroids to acceptable dose after 3 months W/O having symptom recurrence (circle one): ☐ Yes ☐ No	There was contraindication to 6-MP, AZA, AND injectable MTX (circle one): ☐ Yes ☐ No
☐ STEROID REFRACTORY	There was inadequate response OR intolerable side effect to IV glucocorticoids after 7-10 days (circle one): ☐ Yes ☐ No	There was inadequate response OR intolerable side effect to oral prednisone ≥40mg per day after 30 days (circle one): ☐ Yes ☐ No

☐ Hidradenitis Suppurativa (Acne Inversa)							
Does member have moderate to severe disease (Hurley stage II-III)?	☐ Yes	☐ No	Was there trial AND failure of 90-day treatment with oral antibiotics (doxycycline, minocycline OR clindamycin with rifampin)?	☐ Yes	☐ No		
☐ Behçet's Disease							
Does member have ACTIVE RECURRENT oral ulcers?	☐ Yes	☐ No	Was there trial AND failure with ONE Non-Biologic DMARD (MTX, LEF, SSZ OR HCQ)?	☐ Yes	☐ No		
☐ Uveitis							
Was intermediate, posterior OR pan uveitis caused by infection?	☐ Yes	☐ No	There was inadequate response OR intolerable side effect with following:	☐ cyclosporine	☐ tacrolimus	☐ Corticosteroids	
				☐ MTX	☐ AZA	☐ MMF	
Are medications such as corticosteroids, MTX, AZA, MMF, cyclosporine, AND tacrolimus are NOT appropriate?						☐ Yes	☐ No
☐ Cytokine Release Syndrome							
Is diagnosis grade 3 OR 4, severe OR life-threatening due to chimeric antigen receptor-T cell therapy?						☐ Yes	☐ No

Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records

Signature affirms that information given on this form is true and accurate and reflects office notes.

Prescribing Provider's Signature: _____ **Date:** _____

Please note: Incomplete forms or forms without the chart notes will be returned

Office notes, labs, and medical testing relevant to the request that show medical justification are required.

Standard turnaround time is 24 hours. You can call 800-624-3879 to check the status of a request.