Cytokine and CAM Antagonists: IL-6 Inhibitors

Please fax this completed form to (833) 645-2734 OR mail to: Centene Pharmacy Services | 5 River Park Place East, Suite 210 | Fresno, CA 93720. You can also complete online at CoverMyMeds.com.

Coordinated Care of Washington, Inc. (Apple Health) Preferred Drug list: https://www.coordinatedcarehealth.com/content/dam/centene/centene-pharmacy/pdl/FORMULARY-CoordinatedCare_Washington.pdf

For policy criteria, see: https://www.coordinatedcarehealth.com/content/coordinatedcare/en_us/providers/resources/clinical-payment-policies.html/

Date of request:	Reference #:	MAS:	
Patient	Date of birth	ProviderOne ID or Coordinated Care ID	
Pharmacy name	Pharmacy NPI	Telephone number	Fax number
Prescriber	Prescriber NPI	Telephone number	Fax number
Medication and strength	Directions for use	Qty/Days supply	

1. Is this request for a continuation of therapy? ☐ Yes ☐ No
   If yes, does patient have clinical documentation demonstrating disease stability or a positive clinical response? ☐ Yes ☐ No

2. Is this prescribed by, or in consultation with, any of the following? Check all that apply:
   ☐ Pulmonologist ☐ Rheumatologist ☐ Other. Specify: _____

3. Will the requested medication be used in combination with another Cytokine and CAM medication?
   ☐ Yes ☐ No

4. If request is non-preferred, has patient had treatment with one or more preferred Cytokine and CAM medications on the Apple Health Preferred Drug List (AHPDL) that was ineffective, contraindicated or not tolerated?
   ☐ Yes. List each medication and duration of trial:

   Medication Name: _____ Duration: _____
   Medication Name: _____ Duration: _____
   Medication Name: _____ Duration: _____

   ☐ No. Explain why a preferred product(s) have not been tried: _____

5. What is patient current weight: _____kg Date taken: _____

6. Indicate patient's diagnosis and answer the associated questions as indicated:
   ☐ Giant Cell Arteritis (questions 7 - 9)
   ☐ Polyarticular Juvenile Idiopathic Arthritis (questions 10 - 11)
   ☐ Polymyalgia Rheumatica (questions 12 - 14)
   ☐ Rheumatoid Arthritis (questions 15 - 17)

☐ Systemic Juvenile Idiopathic Arthritis (questions 18 - 21)
☐ Systemic Sclerosis-Associated Interstitial Lung Disease (questions 22 - 25)

For diagnosis of Giant Cell Arteritis:

7. Does patient have a presence of any of the following? Check all that apply:
   ☐ Age at disease onset of at least 50 years
   ☐ New onset headache at time of diagnosis
   ☐ Temporary artery abnormality (tenderness to palpation or decreased pulsation)
   ☐ Elevated ESR
   ☐ Abnormal artery biopsy

8. Does patient have a history of failure, contraindication, or intolerance to at least one glucocorticoid (i.e., prednisone, hydrocortisone, methylprednisolone, etc.)? ☐ Yes ☐ No

9. **For continuation of therapy:** Has documentation been submitted demonstrating disease stability or a positive clinical response (e.g. improve in headache, temporal artery tenderness, visual symptoms, steroid free clinical remission, CRP, ESR)? ☐ Yes ☐ No

For diagnosis of Polyarticular Juvenile Idiopathic Arthritis

10. Has patient had treatment with at least one non-Cytokine and CAM DMARD (e.g., methotrexate, sulfasalazine, leflunomide, hydroxychloroquine, azathioprine, cyclosporine) that has been ineffective, unless all are contraindicated, or not tolerated [minimum trial of 3 months]? ☐ Yes ☐ No

11. **For continuation of therapy:** Has documentation been submitted demonstrating disease stability or a positive clinical response (e.g., improvement in joint pain, swelling, activities of daily living, reduction in diseases flares, etc.)? ☐ Yes ☐ No

For diagnosis of Polymyalgia Rheumatica

12. Does patient have a presence of any of the following? Check all that apply:
   ☐ Bilateral shoulder or pelvic girdle pain lasting at least 2 weeks
   ☐ Morning stiffness for greater than 45 minutes
   ☐ Elevated C-reactive protein (CRP) or erythrocyte sedimentation rate (ESR)

13. Has patient had a history of failure, contraindication, or intolerance to at least one glucocorticoid (i.e., prednisone, hydrocortisone, methylprednisolone, etc.) and attempted dose reduction/taper that has been ineffective, unless all are contraindicated, or not tolerated [minimum trial of 2 months]?
   ☐ Yes ☐ No

14. **For continuation of therapy:** Has documentation been submitted demonstrating disease stability or a positive clinical response (e.g., reduction of elevated inflammatory markers the CRP and ESR, improvement of bilateral shoulder and/or pelvic girdle pain, reduction of duration of daily morning stiffness)?
   ☐ Yes ☐ No

For diagnosis of Rheumatoid Arthritis (RA)

15. Have baseline assessments been submitted (e.g., Disease Activity Score for 28 joints (DAS28) with the CRP, DAS28 with ESR, Simplified Disease Activity Index (SDAI), Clinical Disease Activity Index (CDAI), Routine Assessment of Patient Index Data 3 (RAPID3), Patient Activity Scale (PAS) II? ☐ Yes ☐ No

16. Has patient had treatment with at least one non-Cytokine and CAM DMARD (e.g., methotrexate, sulfasalazine, hydroxychloroquine, leflunomide, cyclosporine, azathioprine) that has been ineffective, unless all are contraindicated, or not tolerated [minimum trial of 3 months]? ☐ Yes ☐ No

17. **For continuation of therapy:** Has documentation been submitted demonstrating disease stability or a positive clinical response (e.g. improvement in DAS28 with CRP/ESR, SDAI, CDAI, RAPID3, PAS II scores)?
☐ Yes ☐ No

For diagnosis of Systemic Juvenile Idiopathic Arthritis

18. Does patient have presence of active, severe disease indicated by any of the following? Check all that apply:
☐ Suspected early macrophage activating syndrome (MAS)
☐ Disabling polyarthritis
☐ Serositis

19. Does patient have history of failure, contraindication, or intolerance to any of the following? Check all that apply:
☐ NSAID (e.g., ibuprofen, naproxen, indomethacin, meloxicam, celecoxib, etc.) [minimum trial of 1 week]
☐ Glucocorticoid (i.e., prednisone, hydrocortisone, methylprednisolone, etc.) [minimum trial of 2 weeks]

20. Has patient had treatment with at least one non-Cytokine and CAM disease-modifying antirheumatic drug (DMARD) that has been ineffective, contraindicated or not tolerated [minimum trial of 3 months]?
☐ Yes ☐ No

21. **For continuation of therapy:** Has documentation been submitted demonstrating disease stability or a positive clinical response (e.g., improvement in joint pain or stiffness)? ☐ Yes ☐ No

For diagnosis of Systemic Sclerosis-Associated Interstitial Lung Disease

22. Will the requested medication be used in combination with nintedanib (Ofev) or pirfenidone (Esbriet)?
☐ Yes ☐ No

23. Has diagnosis been confirmed by a high resolution computed tomographic (HRCT) scan?
☐ Yes ☐ No

24. Has patient had treatment with at least one immunomodulator (e.g., mycophenolate or cyclophosphamide) that has been ineffective, unless all are contraindicated, or not tolerated [minimum trial of 3 months]?
☐ Yes ☐ No

25. **For continuation of therapy:** Has documentation been submitted demonstrating disease stability or a positive clinical response (e.g., sustained forced vital capacity (%FVC) decline or minimal decline in diffusing capacity of the lung for carbon monoxide (DLCO))? ☐ Yes ☐ No

CHART NOTES ARE REQUIRED WITH THIS REQUEST

Prescriber signature	Prescriber specialty	Date

Centene Pharmacy Services will respond via fax or phone within 24 hours of receipt of the request. Requests for prior authorization must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)