Cytokine and CAM Antagonists: IL-12/IL-23 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:
   ☐ Dermatologist ☐ Gastroenterologist ☐ 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:
   ☐ Crohn's Disease (questions 7 - 9)
   ☐ Plaque Psoriasis (questions 10 – 14)
   ☐ Psoriatic Arthritis (PsA) (questions 15 - 18)

☐ Ulcerative Colitis (questions 19 - 21)

For diagnosis of Crohn's Disease (CD)

7. Has treatment with any of the following conventional therapies that have been ineffective, contraindicated, or not tolerated? Check all that apply:
   ☐ Oral corticosteroids (e.g., prednisone, methylprednisolone) used short-term to induce remission or alleviate signs/symptoms of disease flare
   ☐ Immunomodulatory agent (e.g., methotrexate, azathioprine, 6-mercaptopurine) [minimum trial of 12 weeks]

8. Does patient have documentation of high-risk disease (e.g., symptoms despite conventional therapy, obstruction, abscess, stricture, phlegmon, fistulas, resection, extensive bowel involvement, early age of onset, growth retardation, Crohn's Disease Activity Index (CDAI) > 450, Harvey-Bradshaw index > 7)? ☐ Yes ☐ No

9. **For continuation of therapy:** Has documentation been submitted demonstrating disease stability or a positive clinical response (e.g., improvement in endoscopic activity, taper or discontinuation of corticosteroids, reduction in number of liquid stools, decrease in presence and severity of abdominal pain, decrease in CDAI, decrease in Harvey-Bradshaw index)? ☐ Yes ☐ No

For diagnosis of Plaque Psoriasis

10. Does patient have presence of ongoing disease for greater than 6 months? ☐ Yes ☐ No

11. Please indicate the following for patient:
    ☐ Disease affects at least 10% body surface area ☐ Disease affects the face, ears, hands, feet, or genitalia

12. Have baseline assessments been submitted (e.g., body surface area (BSA), Psoriasis Area and Severity Index (PASI), Psoriasis Physician's Global Assessment (PGA), itch numeric rating scale, etc.)? ☐ Yes ☐ No

13. Has patient had a history of failure, contraindication, or intolerance to the following? Check all that apply:
    ☐ Phototherapy (UVB or PUVA) [minimum trial of 12 weeks]
    ☐ Treatment with at least one non-Cytokine and CAM DMARD (e.g., methotrexate, cyclosporine, acitretin, azathioprine, etc.) [minimum trial of 12 weeks]

14. **For continuation of therapy:** Has documentation been submitted demonstrating disease stability or a positive clinical response (e.g., improvement in BSA, PSAI, Psoriasis PGA, itch numeric rating scale)? ☐ Yes ☐ No

For diagnosis of Psoriatic Arthritis

15. 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

16. Does patient have presence of active, severe disease indicated by provider assessment?
    ☐ Yes ☐ No

17. Does patient have presence of any of the following? Check all that apply:
    ☐ Erosive disease
    ☐ Elevated C-reactive protein (CRP) or erythrocyte sedimentation rate (ESR)
    ☐ Long-term damage interfering with function (e.g., joint deformities, vision loss)

☐ Major impairment of quality of life due to high disease activity at many sites (including dactylitis, enthesitis) or functionally limiting arthritis at a few sites.

18. **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 Ulcerative Colitis

19. Have baseline assessments been submitted (e.g., stool frequency, endoscopy results, presence of rectal bleeding, disease activity scoring tool)? ☐ Yes ☐ No

20. Has treatment with conventional therapy (e.g., systemic corticosteroids, azathioprine, mesalamine, sulfasalazine) been ineffective, unless all are contraindicated, or not tolerated [minimum trial of 12 weeks]?
☐ Yes ☐ No

21. **For continuation of therapy:** Has documentation been submitted demonstrating disease stability or a positive clinical response (e.g., decreased stool frequency, decreased rectal bleeding, improvement in endoscopic activity, tapering or discontinuation of corticosteroid therapy, or improvement on a disease activity scoring tool)?
☐ 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.)