Cytokine and CAM Antagonists: IL-17 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 ☐ 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:
   ☐ Ankylosing Spondylitis (questions 7-11)
   ☐ Enthesitis-related arthritis (questions 12 -13)
   ☐ Hidradenitis Suppurativa (HS) (questions 14 -17)
   ☐ Non-radiographic axial spondyloarthritis (questions 7-11)

☐ Plaque Psoriasis (questions 18 - 22)
☐ Psoriatic Arthritis (PsA) (questions 23 - 26)

For diagnosis of Ankylosing Spondylitis or Non-radiographic axial spondyloarthritis:

7. Does patient have high disease activity as indicated by one of the following?
   ☐ Bath Ankylosing Disease Activity Index (BASDAI) score of at least 4
   ☐ Ankylosing Spondylitis Disease Activity Score (ASDAS) score of at least 2.1

8. Has patient had treatment with at least two different NSAIDs that has been ineffective, contraindicated or not tolerated [minimum trial of four weeks]? ☐ Yes ☐ No

9. Has patient's disease manifested as one of the following?
   ☐ Axial disease ☐ Peripheral arthritis

10. 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

11. **For continuation of therapy:** Has documentation been submitted demonstrating disease stability or a positive clinical response (e.g., decrease in BASDAI or ASDAS score)? ☐ Yes ☐ No

For diagnosis of Enthesitis-related arthritis

12. 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

13. **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 Hidradenitis Suppurativa (HS)

14. Does patient have presence of inflammatory nodules and/or abscesses? ☐ Yes ☐ No

15. Does patient have diagnosis of one of the following?
    ☐ Hurley Stage III (severe) disease ☐ Hurley Stage II (moderate) disease

16. Does patient have a history of failure, contraindication, or intolerance to at least one oral antibiotic (i.e., doxycycline, minocycline, tetracycline, clindamycin + rifampin, etc.) [minimum trial of 3 month trial]
    ☐ Yes ☐ No

17. **For continuation of therapy:** Has documentation been submitted demonstrating disease stability or a positive clinical response (e.g., reduction in abscess or inflammatory nodules)? ☐ Yes ☐ No

For diagnosis of Plaque Psoriasis

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

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

20. 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

21. 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]

22. **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

23. 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

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

25. 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.

26. **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

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.)