Cytokine and CAM Antagonists: Tumor Necrosis Factor (TNF) 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:
   ☐ Cardiologist ☐ Dermatologist ☐ Immunologist
   ☐ 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:
   ☐ Adult onset Still's disease (questions 27 – 30)
   ☐ Cryopyrin-Associated Periodic Syndromes (questions 7 – 10)

- ☐ Deficiency of IL-1 Receptor Antagonist (questions 11 – 14)
- ☐ Familial Mediterranean Fever (questions 15 – 18)
- ☐ Gout Flare (questions 19 – 22)
- ☐ Hyperimmunoglobulin D Syndrome/Mevalonate Kinase Deficiency (questions 23 – 26)
- ☐ Systemic Juvenile Idiopathic Arthritis (questions 27 – 30)
- ☐ Recurrent Pericarditis (questions 31 – 34)
- ☐ Rheumatoid Arthritis (questions 35 - 37)
- ☐ Schnitzler Syndrome (questions 38 – 40)
- ☐ Tumor Necrosis Factor Receptor-Associated Periodic Syndrome (questions 41 – 45)

For diagnosis Cryopyrin-Associated Periodic Syndromes

7. Does patient have any of the following? Check all that apply:
   - ☐ Neonatal-onset multisystem inflammatory disease (NOMID)
   - ☐ Familial cold autoinflammatory syndrome (FCAS)
   - ☐ Muckle-Wells Syndrome (MWS)

8. Has patient had laboratory testing showing a genetic mutation in the Cold-Induced Auto-inflammatory Syndrome 1 (CIAS1), also known as NLRP? ☐ Yes ☐ No

9. Have baseline assessments been submitted (e.g., C-reactive protein (CRP), serum amyloid A, rash frequency)? ☐ Yes ☐ No

10. **For continuation of therapy:** Has documentation been submitted demonstrating disease stability or a positive clinical response (e.g. improvement in CRP, serum amyloid A, rash frequency)? ☐ Yes ☐ No

For diagnosis of Deficiency of IL-1 Receptor Antagonist

11. Does patient have documentation of mutation in the *IL1RN* gene? ☐ Yes ☐ No

12. Have baseline assessments been submitted (e.g. erythrocyte sedimentation rate (ESR), C-reactive protein (CRP) ECG, skin biopsy, MRI, X-rays)? ☐ Yes ☐ No

13. Has patient experienced any of the following symptoms? Check all that apply:
   - ☐ Pustular psoriasis-like rash
   - ☐ Sterile osteomyelitis (i.e., rib flaring and cloaking of the femoral head, odontoid lesions)
   - ☐ Nail changes (i.e., onychomadesis)

14. **For continuation of therapy:** Has documentation been submitted demonstrating disease stability or a positive clinical response (e.g., improvement in rash and x-rays)? ☐ Yes ☐ No

For diagnosis of Familial Mediterranean Fever

15. Has patient had recurrent febrile episodes accompanied by any of the follow? Check all that apply:
   - ☐ Erysipelas-like erythema
   - ☐ First degree relative with Familial Mediterranean Fever
   - ☐ Peritonitis
   - ☐ Synovitis or pleuritis

16. Have causes of recurrent fever have been ruled out (e.g., recurrent bacterial/viral infection, cyclic neutropenia, interferonopathies, etc.)? ☐ Yes ☐ No

17. Has patient had a history of failure, contraindication, or intolerance to colchicine [minimum trial of 3 months]?

☐ Yes ☐ No

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

For diagnosis of Gout Flare

19. Has patient experienced ≥ 2 gout flares within the previous 12 months? ☐ Yes ☐ No

20. Has patient had a history of failure to any of the following, unless contraindicated or not tolerated? Check all that apply:
    ☐ Colchicine [minimum trial of 12 weeks]
    ☐ Non-steroidal anti-inflammatory drugs (NSAIDs) (e.g., naproxen, indomethacin, diclofenac, meloxicam, celecoxib) [minimum trial of 2 weeks]
    ☐ Intraarticular or oral glucocorticoids (e.g. methylprednisolone acetate, triamcinolone acetonide, prednisone, prednisolone) [minimum trial of 1 week].

21. Has patient received treatment with canakinumab in the previous 12 weeks? ☐ Yes ☐ No

22. **For continuation of therapy:** Has documentation been submitted demonstrating disease stability or a positive clinical response (e.g. reduction in gout flares)? ☐ Yes ☐ No

For diagnosis of Hyperimmunoglobulin D Syndrome/Mevalonate Kinase Deficiency

23. Does patient have documentation of any of the following? Check all that apply:
    ☐ Elevated immunoglobulin D (IgD) levels
    ☐ V3771 mutation in the mevalonate kinase gene
    ☐ Fever flares that last four days or more

24. Are fever flares are accompanied with any of the following symptoms? Check all that apply:
    ☐ Chills
    ☐ Cervical lymphadenopathy
    ☐ Abdominal symptoms (e.g., pain, vomiting, diarrhea)
    ☐ Lymphadenopathy

25. Have causes of recurrent fever have been ruled out (e.g., recurrent bacterial/viral infection, cyclic neutropenia, interferonopathies, etc.)? ☐ Yes ☐ No

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

For diagnosis of Systemic Juvenile Idiopathic Arthritis or adult onset Still's Disease

27. 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

28. 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]

29. 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

30. **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 Recurrent Pericarditis

31. Has patient had three or more episodes of pericarditis? ☐ Yes ☐ No

32. Have baseline assessments been submitted (e.g. white blood cell count (WBC), erythrocyte sedimentation rate (ESR), C-reactive protein (CRP) ECG)? ☐ Yes ☐ No

33. 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 2 weeks]
☐ Colchicine [minimum trial of 12 weeks]
☐ Corticosteroids (e.g., prednisone) [minimum trial of 2 weeks]

34. **For continuation of therapy:** Has documentation been submitted demonstrating disease stability or a positive clinical response (e.g., improvement in pleuritic chest pain and ECG changes)? ☐ Yes ☐ No

For diagnosis of Rheumatoid Arthritis (RA)

35. 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

36. 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

37. **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 Schnitzler Syndrome

38. Does patient have documentation of monoclonal immunoglobulin (IgM) gammopathy? ☐ Yes ☐ No

39. Does patient have a presence of a chronic urticaria-like rash? ☐ Yes ☐ No

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

For diagnosis of Tumor Necrosis Factor Receptor-Associated Periodic Syndrome

41. Does patient have documentation of TNFRSF1A gene mutation? ☐ Yes ☐ No

42. Does patient have documentation of any of the following? Check all that apply:
☐ Three or more fever flares a year
☐ Fever flares that last five days or more

43. Are fever flares are accompanied with any of the following symptoms? Check all that apply:
☐ Myalgia
☐ Rash

☐ Eye symptoms (e.g., conjunctivitis, periorbital edema)
☐ Limb pain
☐ Abdominal symptoms (e.g., pain, vomiting)
☐ Lymphadenopathy
☐ Chest pain

44. Have causes of recurrent fever have been ruled out (e.g., recurrent bacterial/viral infection, cyclic neutropenia, interferonopathies, etc.)? ☐ Yes ☐ No

45. **For continuation of therapy:** Has documentation been submitted demonstrating disease stability or a positive clinical response (e.g., reduction in fever flares)? ☐ 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.)