DisclosedRx
The Fiduciary and Fully Disclosed PBM®

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# Prior Authorization Request Form

## Immunomodulator Agents

☐ Standard ☐ Urgent ☐ Reconsideration/Appeal

### Patient Information

Patient Name: _____ DOB (mm/dd/yyyy): _____ Gender: _____

Address: _____ City: _____ State & Zip: _____

Cardholder ID: _____ Group #: _____ Relationship Code: _____

Phone Number: _____ Email address: _____

### Prescriber Information

Prescriber Name: _____ Specialty: _____ NPI: _____

Address: _____ City: _____ State & Zip: _____

Office Contact: _____ Phone Number: _____ Fax Number: _____

### Medication Information

Drug Name: _____ Strength: _____ Quantity: _____

Directions: _____ Day Supply: _____

Indicate Request Type: ☐ New Start ☐ Renewal Therapy Start Date (if applicable): _____

Diagnosis: _____ ICD 10 Code: _____

### Prior Authorization Request Information

***Supporting documentation (i.e., chart notes, labs, etc.) must be attached to avoid processing delays***

*Please be aware that our preferred Humira biosimilars are adalimumab-aacf, adalimumab-aaty, adalimumab-fkjp, Hadlima, Simlandi, & Yusimry*

For all requests:

1. Does the patient have any FDA contraindications to the requested agent? ☐ Yes ☐ No
2. Is the requested agent being prescribed by or in consultation with an appropriate specialist? ☐ Yes ☐ No
3. Will the requested agent be used in combination with any other biologic DMARD or targeted synthetic DMARD? If yes, please explain: _____ ☐ Yes ☐ No
4. Has the patient been tested negative for TB? Please provide documentation of results. ☐ Yes ☐ No
5. If positive for latent TB, has the patient completed treatment (or is receiving treatment)? ☐ Yes ☐ No
6. Does the provider attest that the patient does not have an active infection (including tuberculosis and hepatitis B virus (HBV), and the patient has been counseled on next steps if they were to develop an active infection? ☐ Yes ☐ No
7. Will the patient receive any live vaccines while on therapy? ☐ Yes ☐ No

**Please continue to the next page.**

| Patient Name: | DOB: |
|---|---|

**For Rheumatoid Arthritis Requests:**

1. **Does the patient have moderate-to-severe rheumatoid arthritis?** ☐**Yes** ☐**No**
2. **Has the patient had an inadequate clinical response, intolerance, or contraindication to at least 3 months of ONE conventional systemic DMARD therapy (i.e., azathioprine, cyclosporine, hydroxychloroquine, leflunomide, methotrexate, mycophenolate, or sulfasalazine)?** ☐**Yes** ☐**No**

| Drug Name/Strength: | Start Date: | End Date: | Outcome: |
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**For Psoriatic Arthritis Requests:**

3. **Does the patient have moderate-to-severe psoriatic arthritis?** ☐**Yes** ☐**No**
4. **Has the patient had an inadequate clinical response, intolerance, or contraindication to at least 3 months of ONE conventional systemic DMARD therapy (i.e., azathioprine, cyclosporine, hydroxychloroquine, leflunomide, methotrexate, mycophenolate, or sulfasalazine)?** ☐**Yes** ☐**No**

| Drug Name/Strength: | Start Date: | End Date: | Outcome: |
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**For Psoriasis Requests:**

5. **Does the patient have moderate-to-severe psoriasis?** ☐**Yes** ☐**No**
6. **Which of the following applies to the patient?**
   ☐**>10% BSA involvement** ☐**Intractable pruritus** ☐**Other:** _____
   ☐**Psoriasis occurring on select locations (i.e., hands, feet, scalp, face, or genitals)**
7. **Has the patient had an inadequate clinical response, intolerance, or contraindication to at least 3 months of ONE conventional therapy (i.e., acitretin, anthralin, calcipotriene, calcitriol, coal tar products, cyclosporine, methotrexate, pimecrolimus, PUVA [phototherapy], tacrolimus, tazarotene, topical corticosteroids)?** ☐**Yes** ☐**No**

| Drug Name/Strength: | Start Date: | End Date: | Outcome: |
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**For Ulcerative Colitis Requests:**

8. **Does the patient have moderate-to-severe ulcerative colitis?** ☐**Yes** ☐**No**
9. **Has the patient had an inadequate clinical response, intolerance, or contraindication to at least 3 months of ONE conventional therapy (i.e., 6-mercaptopurine, azathioprine, balsalazide, corticosteroids, cyclosporine, mesalamine, sulfasalazine)?** ☐**Yes** ☐**No**

| Drug Name/Strength: | Start Date: | End Date: | Outcome: |
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**Please continue to the next page.**

| Patient Name: | DOB: |
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**For Crohn's Disease Requests:**

10. **Does the patient have moderate-to-severe Crohn's disease?** ☐**Yes** ☐**No**
11. **Has the patient had an inadequate clinical response, intolerance, or contraindication to at least 3 months of ONE conventional therapy (i.e., 6-mercaptopurine, azathioprine, balsalazide, corticosteroids, cyclosporine, mesalamine, sulfasalazine)?** ☐**Yes** ☐**No**

| Drug Name/Strength: | Start Date: | End Date: | Outcome: |
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**For Uveitis Requests:**

12. **Has the patient had an inadequate clinical response, intolerance, or contraindication to at least 3 months of ONE conventional therapy (i.e., corticosteroids, methotrexate, azathioprine, mycophenolate mofetil)?** ☐**Yes** ☐**No**

| Drug Name/Strength: | Start Date: | End Date: | Outcome: |
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**For Ankylosing Spondylitis Requests:**

13. **Has the patient had an inadequate clinical response, intolerance, or contraindication to at least 3 months of TWO conventional therapy (i.e., NSAIDs – ibuprofen, naproxen, etodolac, celecoxib)?** ☐**Yes** ☐**No**

| Drug Name/Strength: | Start Date: | End Date: | Outcome: |
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**For Hidradenitis Suppurativa Requests:**

14. **Has the patient had an inadequate clinical response, intolerance, or contraindication to at least 3 months of ONE conventional therapy (i.e., systemic antibiotic therapy [clindamycin, minocycline, doxycycline, rifampin], metformin, oral contraceptives, spironolactone)?** ☐**Yes** ☐**No**

| Drug Name/Strength: | Start Date: | End Date: | Outcome: |
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**Please continue to the next page.**

| Patient Name: | DOB: |
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**For Atopic Dermatitis Requests:**

15. **Does the patient have moderate-to-severe atopic dermatitis?** ☐**Yes** ☐**No**
16. **Which of the following applies to the patient?**
    ☐**≥ 10% BSA** ☐**≥7 EASI score** ☐**≥ 29 SCORAD score** ☐**≥ 3 IGA score** ☐**Other: _____**
17. **Has the patient had an inadequate clinical response, intolerance, or contraindication to at least 4 weeks of TWO topical steroids OR the affected areas are difficult to treat with prolonged topical corticosteroid exposure (i.e., hands, feet, face, scalp, genitals)?** ☐**Yes** ☐**No**
18. **Has the patient had an inadequate clinical response, intolerance, or contraindication to at least 6 weeks of ONE topical calcineurin inhibitor (i.e., pimecrolimus, tacrolimus)?** ☐**Yes** ☐**No**
19. **Has the patient had an inadequate clinical response, intolerance, or contraindication to at least 3 months of ONE conventional systemic therapy?** ☐**Yes** ☐**No**

| Drug Name/Strength: | Start Date: | End Date: | Outcome: |
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**For Renewal Requests:**

20. **Has the patient's condition improved or stabilized with therapy (i.e., reduction in inflammation/joints affected, affected body surface area, symptom reduction, or endoscopic improvement)? Please provide documentation.** ☐**Yes** ☐**No**
21. **Is the requested agent being used in combination with any other biologic DMARD or targeted synthetic DMARD?** ☐**Yes** ☐**No**
22. **Will the patient receive any live vaccines while on therapy?** ☐**Yes** ☐**No**
23. **Does the patient have any FDA contraindications to the requested agent?** ☐**Yes** ☐**No**

**Prescriber Signature**: _____ **Date**: _____

**Authorized Agent's Name:** _____

**Please fax this request to 602-585-0588 or our secure email at care@disclosedrx.com**
**Mail Requests to: DisclosedRx Clinical Team**
**PO Box 701 Washington, IN 47501**

**Additional Comments/Notes:**