



Anti-Inflammatory Therapy Step Therapy
Cimzia (certolizumab pegol) J0717, Spevigo (spesolimab-sbzo) J1747, Skyrizi (risankizumab-rzaa) J2327, Ilumya (tildrakizumab) J3245 are non-preferred. The preferred products are Simponi (Golimumab) J1602, Stelara (Ustekinumab; SubQ and IV) J3357/J3358

**Prior Authorization Request
 Medicare Part B Form**

*Instructions: * Indicates required information – Form may be returned if required information is not provided. Please fax this request to the appropriate fax number listed at the bottom of the page.*

<input type="checkbox"/>	Standard Request– (72 Hours)	<input type="checkbox"/>	Urgent Request (standard time frame could place the member's life, health or ability in serious jeopardy)
Date Requested _____			
Requestor _____ Clinic name: _____ Phone _____ / Fax _____			

MEMBER INFORMATION

*Name: _____ *ID#: _____ *DOB: _____

PRESCRIBER INFORMATION

*Name: _____ MD FNP DO NP PA *Phone: _____

*Address: _____ *Fax: _____

DISPENSING PROVIDER / ADMINISTRATION INFORMATION

*Name: _____ Phone: _____

*Address: _____ Fax: _____

PROCEDURE / PRODUCT INFORMATION

HCCP Code	Name of Drug	Dose (Wt: _____ kg Ht: _____)	Frequency	End Date if known

Self-administered Provider-administered Home Infusion

Chart notes attached. **Other important information:** _____

Diagnosis: ICD10: _____ **Description:** _____

Provider attests the diagnosis provided is an FDA-Approved indication for this drug

CLINICAL INFORMATION

New Start or Initial Request: (Clinical documentation required for all requests)
 Provider has reviewed the attached “Criteria for Approval” and attests the member meets ALL required PA criteria.
 If not, please provide **clinical rationale** for formulary exception: _____

Continuation Requests: (Clinical documentation required for all requests)
 Provider has reviewed the attached “Criteria for Continuation” and attests the member meets ALL required PA Continuation criteria.
 Patient had an adequate response or significant improvement while on this medication.
 If not, please provide clinical rationale for continuing this medication: _____

ACKNOWLEDGEMENT

Request By (Signature Required): _____ **Date:** ____ / ____ / ____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. THIS AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT. PAYMENT IS BASED ON BENEFITS IN EFFECT AT THE TIME OF SERVICE, MEMBER ELIGIBILITY AND MEDICAL NECESSITY.

Prior Authorization Group – Anti-Inflammatory Therapy PA

Drug Name(s):

CIMZIA	CERTOLIZUMAB PEGOL
SIMPONI	GOLIMUMAB
ILUMYA	TILDRAKIZUMAB-ASMN
STELARA	USTEKINUMAB
SKYRIZI	RISANKIZUMAB-RZAA
SPEVIGO	SPELIMAB-SBZO

Criteria for approval of Prior Authorization Drug:

1. Prescribed for an approved FDA diagnosis (as listed below):
2. Member has tried and failed at least ONE of the formulary alternatives: **Simponi or Stelara** OR
 - There is clinical documentation stating formulary alternatives are contraindicated.
3. Member does not have any clinically relevant contraindications, or CMS/Plan exclusions, to the requested drug.
 - If the member meets all these criteria, they may be approved by the Plan for the requested drug.
 - Quantity limits and Tiering will be determined by the Plan.

Exclusion Criteria:

N/A

Prescriber Restrictions:

N/A

Coverage Duration:

Approval will be for 12 months

FDA Indications:

Cimzia

- Ankylosing spondylitis, Active
- Crohn's disease, Active, moderate to severe
- Non-radiographic axial spondyloarthritis
- Plaque psoriasis, Moderate to severe
- Psoriatic arthritis, Active
- Rheumatoid arthritis, Active, moderate to severe

Ilumya

- Plaque psoriasis (Moderate to Severe), In candidates for systemic therapy or phototherapy

Simponi

- Ankylosing spondylitis, Active
- Polyarticular juvenile idiopathic arthritis, Active
- Psoriatic arthritis, Active
- Rheumatoid arthritis (Moderate to Severe), Active, in combination with methotrexate
- Ulcerative colitis (Moderate to Severe), Active

Spevigo

- Crohn's disease, Moderately to Severely Active
- Plaque psoriasis (Moderate to Severe), Eligible for systemic therapy or phototherapy

- Psoriatic arthritis, Active

Stelara

- Crohn's disease (Moderate to Severe), Failed or intolerant to a tumor necrosis factor antagonist
- Crohn's disease (Moderate to Severe), Failed or intolerant to immunomodulators or corticosteroids
- Plaque psoriasis (Moderate to Severe)
- Psoriatic arthritis, Active, alone or in combination with methotrexate
- Ulcerative colitis (Moderate to Severe), Active

Spevigo

- Generalized pustular psoriasis, Flares

Off-Label Uses:

Simponi, Stelara

- Rheumatoid arthritis

Age Restrictions:

N/A

Other Clinical Considerations:

N/A

Resources:

https://www.micromedexsolutions.com/micromedex2/librarian/CS/FE6BE2/ND_PR/evidencexpert/ND_P/evidencexpert/DUPLICATIONSHIELDSYNC/0DF231/ND_PG/evidencexpert/ND_B/evidencexpert/ND_AppProduct/evidencexpert/ND_T/evidencexpert/PFActionId/evidencexpert.DoIntegratedSearch?SearchTerm=tildrakizumab&UserSearchTerm=tildrakizumab&SearchFilter=filterNone&navitem=searchGlobal#

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