aetna™

Aetna Better Health®

Fax completed prior authorization request form to 855-296-0323 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at www.aetnabetterhealth.com/newjersey/providers/pharmacy

Cytokines and Cell Adhesion Molecule (CAM) Antagonists Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification are required to support diagnosis

Member Information				
Member Name (first & last):	Date of Birth:	Gender: ☐ Male ☐ Female		Height:
Member ID:	City:	State:		Weight:
Prescribing Provider Information				
Provider Name (first & last):	Specialty:	NPI#		DEA#
Office Address:	City:	State:		Zip Code:
Office Contact:	Office Phone		Office Fax:	
Dispensing Pharmacy Information				
Pharmacy Name:	Pharmacy Phone:		Pharmacy Fax:	
Requested Medication Information				
Preferred:	☐ **Humira**	☐ **Enbrel**	☐ **Kevzara**	

Requests for Non-Preferred Anti-Tumor Necrosis Factors, such as Cimzia, Remicade, Inflectra, Renflexis and Simponi, require trial and failure of ALL preferred agents where indicated, in addition to all other clinical criteria.

Non-Preferred:	☐ Actemra	☐ Arcalyst	☐ Cimzia	☐ Cosentyx	☐ Taltz	☐ Stelara	☐ Xeljanz
	☐ Ilaris	☐ Ilumya	☐ Inflectra	☐ Kineret	☐ Siliq	☐ Simponi	☐ Tysabri
	☐ Olumiant	☐ Orencia	☐ Remicade	☐ Renflexis	☐ Tremfya	☐ Xeljanz XR	☐ Simponi Aria
	☐ Other, Please specify:						

Requests for other Non-Preferred Cytokines and Cell Adhesion Molecule Antagonists require trial and failure of EITHER Enbrel, Humira or Kevzara where indicated, in addition to all other clinical criteria.

Are there any contraindications to formulary medications?	☐ Yes	☐ No	☐ New request	☐ Continuation of therapy request
☐ If yes, please specify:				
Directions for Use: alkdadasd	Strength:			Dosage Form:
	Quantity:	Day Supply:		Duration of Therapy/Use:

Requests for Non-Preferred Anti-Tumor Necrosis Factors: Cimzia, Remicade, Inflectra, Renflexis and Simponi, require trial and failure of ALL preferred agents where indicated, in addition to all other clinical criteria.

What medication(s) has the member tried and failed for this diagnosis? Please specify below.

Turn-Around Time for Review	
☐ Standard – (24 hours)	☐ **Urgent** – waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: _____

Clinical Information

General Authorization Criteria for ALL Agents and Indications:

Medication request is NOT for an FDA- approved, or compendia-supported diagnosis (circle one): ☐ Yes ☐ No

What is the diagnosis? IDC-10 Code: _____ Diagnosis _____

Is member on another Cytokine or Cell Adhesion Molecule (CAM) Antagonist?	☐ Yes	☐ No	
Is request for Anti-Tumor Necrosis Factors such as Stelara, Xeljanz, Xeljanz XR, Kineret, Actemra, Ilaris, Orencia?	☐ Yes	☐ No	☐ N/A
Was a screen completed for Hepatitis B?	☐ Yes	☐ No	

Does member have active or chronic Hepatitis B?	☐ Yes	☐ No	
If member has active or chronic Hepatitis B, member is receiving appropriate antiviral treatment	☐ Yes	☐ No	☐ N/A
Member has been evaluated for, and given appropriate vaccinations, as recommended per Center for Disease Control for risk factors	☐ Yes	☐ No	
Member has been screened for tuberculosis.	☐ Yes	☐ No	
If screening was positive for latent tuberculosis, member received treatment for latent TB	☐ Yes	☐ No	☐ N/A
Anti-Tumor Necrosis Factors: Member does not have New York Heart Association class III or IV Congestive Heart Failure	☐ Yes	☐ No	☐ N/A
Entyvio and Tysabri: Use as monotherapy and not in combination with antineoplastic, immunosuppressive, or immunomodulating agents (for example, azathioprine, 6-mercaptopurine cyclosporine, methotrexate, tumor necrosis factors inhibitors)	☐ Yes	☐ No	☐ N/A

Additional Criteria Based on Indication:

Rheumatoid Arthritis

There was an inadequate response to a 3-month trial of 2 different non-biologic DMARD regimens (one of which must include methotrexate):

There is an intolerance or contraindication to methotrexate (circle one):
☐ Yes ☐ No

Sulfasalazine, or leflunomide were used due to the intolerance or contraindication to methotrexate (circle one): ☐ Yes ☐ No

Monotherapy:
- ☐ Methotrexate
- ☐ Sulfasalazine
- ☐ Leflunomide

Combination:
- ☐ Methotrexate + sulfasalazine + hydroxychloroquine
- ☐ methotrexate + hydroxychloroquine
- ☐ methotrexate + leflunomide
- ☐ methotrexate + sulfasalazine
- ☐ sulfasalazine + hydroxychloroquine

Systemic Juvenile Idiopathic Arthritis

Are there active systemic features such as fever, evanescent rash, lymphadenopathy, hepatomegaly, splenomegaly, or serositis? (circle one): ☐ Yes ☐ No

Synovitis is in one or more joints despite a 3 months treatment with methotrexate, or leflunomide. (circle one):
Yes ☐ No ☐

Check if one of the following apply:
- ☐ There are active systemic features such as fever, evanescent rash, lymphadenopathy, hepatomegaly, splenomegaly, or serositis, AND synovitis is in at least one joint
- ☐ There are NO active systemic features such as fever, evanescent rash, lymphadenopathy, hepatomegaly, splenomegaly, or serositis, AND synovitis is in one or more joints despite a 3 months treatment with methotrexate, or leflunomide

There are active systemic features such as fever, evanescent rash, lymphadenopathy, hepatomegaly, splenomegaly, or serositis (circle one): ☐ Yes ☐ No

Synovitis is in one or more joints despite a 1-month treatment with Kineret or Actemra AND methotrexate or leflunomide (circle one): ☐ Yes ☐ No

Polyarticular Juvenile Idiopathic Arthritis

Was there an inadequate response to a 3-months trial with methotrexate?	☐ Yes	☐ No	
Was there an intolerance, or a contraindication to methotrexate?	☐ Yes	☐ No	☐ N/A
Was there a trial with sulfasalazine, or leflunomide for 3 months?	☐ Yes	☐ No	☐ N/A

Oligoarticular Juvenile Idiopathic Arthritis

Duration is greater than 6 months?	☐ Yes	☐ No	
Trial and failure of 2 NSAIDs?	☐ Yes	☐ No	(if yes, please indicate drugs tried):
There was a contraindication to the NSAIDs?	☐ Yes	☐ No	☐ N/A
Member had inadequate response or intolerable side effect to a 3-month trial with methotrexate?	☐ Yes	☐ No	☐ N/A
Member has a contraindication to methotrexate?	☐ Yes	☐ No	☐ N/A

Cryopyrin-Associated Periodic Syndromes

Diagnosis is of Cryopyrin-Associated Periodic Syndromes, including neonatal-onset multisystem inflammatory disease, Familial Cold Auto Inflammatory Syndrome, or Muckle-Wells Syndrome (circle one): ☐ Yes ☐ No

One of the following subtypes is present:	☐ Familial Cold Auto Inflammatory Syndrome	☐ Muckle-Wells syndrome
Was there a 3-months trial with Kineret?	☐ Yes	☐ No

Familial Mediterranean Fever

Was there inadequate response, intolerance, or contraindication to colchicine, at maximum indicated dose?	☐ Yes	☐ No

Giant Cell Arteritis

Was there inadequate response with glucocorticoids (for example prednisone, methylprednisolone?	☐ Yes	☐ No

Was there was an intolerance, or contraindication to glucocorticoids?	☐ Yes	☐ No	☐ N/A
If there is intolerance, or contraindication to glucocorticoids, did member have a trial with methotrexate or cyclophosphamide?	☐ Yes	☐ No	☐ N/A
Will Actemra be used in combination with a tapering course of glucocorticoids	☐ Yes	☐ No	

Ankylosing Spondylitis

Is there inadequate response to a one-month trial of 2 NSAIDs?	☐ Yes	☐ No	☐ N/A
Is there a contraindication or intolerance to oral NSAIDs?	☐ Yes	☐ No	☐ N/A

Psoriatic Arthritis

Is the Psoriatic Arthritis ACTIVE?	☐ Yes	☐ No		
Was there an inadequate response to a 3-months trial with methotrexate?	☐ Yes	☐ No	☐ N/A	
Was there intolerance, or contraindication to methotrexate?	☐ Yes	☐ No	☐ N/A	
Was there a trial of sulfasalazine, or leflunomide for 3-months?	☐ Yes	☐ No		
Is disease predominantly AXIAL or ACTIVE ENTHESITIS / DACTYLITIS?	☐ Yes	☐ No		
Was there inadequate response to 1-month trial of 2 NSAIDs?	☐ Yes	☐ No	☐ N/A	
Was there a contraindication or intolerance to the oral NSAIDs?	☐ Yes	☐ No	☐ N/A	

Plaque Psoriasis

Was there inadequate response to at least 1 oral systemic therapy such as methotrexate, or cyclosporine for 3 months or more?	☐ Yes	☐ No	☐ N/A
Was there intolerance, or contraindication to at least 1 oral systemic therapy such as methotrexate, or cyclosporine for 3 months or more?	☐ Yes	☐ No	☐ N/A
Is >10% of Body Surface Area is affected?	☐ Yes	☐ No	
Is less than 10% Body Surface Area is affected, but involves sensitive areas such as hands, feet, face or genitals. that interfere with daily activities?	☐ Yes	☐ No	
Is Psoriasis Area and Severity Index score more than 10?	☐ Yes	☐ No	
Has phototherapy PUVA, UVB been ineffective?	☐ Yes	☐ No	
Is request for Siliq?	☐ Yes	☐ No	
Is there a history of prior suicide attempt, bipolar disorder or depressive disorder?	☐ Yes	☐ No	
Has a mental health evaluation been completed by prescriber or psychiatrist?	☐ Yes	☐ No	☐ N/A

Ulcerative Colitis

☐ STEROID DEPENDENT	A relapse occurred within 3-months of stopping glucocorticoids (circle one): ☐ Yes ☐ No	There was an inadequate response or intolerable side effect to a 3-month trial of mercaptopurine, or azathioprine (circle one): ☐ Yes ☐ No
	There is an Inability to taper steroids to an acceptable dose after 3 months, without having symptom recurrence (circle one): ☐ Yes ☐ No	There was a contraindication with azathioprine AND mercaptopurine? ☐ Yes ☐ No
☐ STEROID REFRACTORY	Inadequate response, or intolerable side effect to IV glucocorticoids after 7-10 days (circle one): ☐ Yes ☐ No	Inadequate response, or intolerable side effect to oral prednisone ≥40mg per day after 30 days (circle one): ☐ Yes ☐ No

There was a trial and failure with mercaptopurine and azathioprine (circle one): ☐ Yes ☐ No	There is contraindication to both mercaptopurine and azathioprine, and member is not a candidate for treatment with these agents for current episode (circle one): Yes ☐ No ☐		
There was inadequate response, or intolerable side effect to cyclosporine?	☐ Yes	☐ No	
There was a contraindication to cyclosporine?	☐ Yes	☐ No	
Member had surgical intervention?	☐ Yes	☐ No	

Crohn's Disease

STEROID DEPENDENT	A relapse occurred within 3-months of stopping glucocorticoids (circle one): ☐ Yes ☐ No	There was an inadequate response, or intolerable side effect, with a 3-month trial of mercaptopurine, or azathioprine, or injectable methotrexate (circle one): ☐ Yes ☐ No
	There is an inability to taper steroids to an acceptable dose after 3 months, without having symptom recurrence (circle one): ☐ Yes ☐ No	There was a contraindication to mercaptopurine, azathioprine, AND injectable methotrexate (circle one): ☐ Yes ☐ No
STEROID REFRACTORY	Inadequate response, or intolerable side effect to IV glucocorticoids after 7-10 days (circle one): ☐ Yes ☐ No	Inadequate response, or intolerable side effect to oral prednisone ≥40mg per day after 30 days (circle one): ☐ Yes ☐ No

Hidradenitis Suppurativa (Acne Inversa)

Member has moderate to severe disease (Hurley stage II-III)	☐ Yes	☐ No	
Trial and failure of a 90-day treatment with oral antibiotics such as doxycycline, minocycline, or clindamycin with rifampin	☐ Yes	☐ No	
Uveitis			
Intermediate, posterior, or pan uveitis is not caused by an infection?	☐ Yes	☐ No	
There was an inadequate response, or intolerable side effect with any of the following: Corticosteroids, methotrexate, azathioprine, mycophenolate, cyclosporine, tacrolimus		☐ Yes	☐ No
Medications such as corticosteroids, methotrexate, azathioprine, mycophenolate, cyclosporine, tacrolimus, are not appropriate		☐ Yes	☐ No
Cytokine Release Syndrome			
Is diagnosis grade 4, severe or life-threatening due to chimeric antigen receptor-T cell therapy?	☐ Yes	☐ No	

Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records.

Signature affirms that information given on this form is true and accurate and reflects office notes.

Prescribing Provider's Signature: _____ **Date:** _____

Please note: Incomplete forms or forms without the chart notes will be returned

Office notes, labs, and medical testing relevant to the request that show medical justification are required

Standard turnaround time is 24 hours. You can call 855-232-3596 to check the status of a request