PRIME THERAPEUTICS®

BIOLOGICS
(Rheumatic, Psoriasis and Gastrointestinal Disorders)
Preauthorization Request Form

Please fill out the ONE page of this form that meets the type of diagnosis for which the product is being prescribed.

Only the prescriber may complete this form for prospective reviews.
The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit NebraskaBlue.com. *Start saving time by filling out this preauthorization form electronically at* MedicalPolicy.NebraskaBlue.com.

What is the priority level of this request?

☐ Standard review - Completed within 15 calendar days of receipt.

☐ Expedited/Urgent review - If the standard time period for a decision could seriously jeopardize the life or health of patient could not be adequately managed; completed within 72 hours of receipt.

Today's Date: _____

Patient Information

Patient Name (First):	Last:	MI:	DOB (mm/dd/yyyy):	Telephone Number:

Insurance Information

BCBS ID Number:

Physician/Clinic Information

Prescriber Name:	Physician UPIN#:	Physician NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:			
City, State, Zip Code:		Phone Number:		Secure Fax Number:

Rheumatic Disorders - Preauthorization Information

Medication Requested (please check): ☐ Actemra ☐ Cimzia ☐ Enbrel ☐ Humira ☐ Kineret ☐ Orencia ☐ Otezla ☐ Remicade
☐ Rituxan ☐ Simponi ☐ Stelara ☐ Xeljanz ☐ Other: _____

1. Patient's diagnosis to be treated with requested medication (ICD 10 code): _____
2. Dosing regimen of requested medication (example: 40mg subcutaneously every other week): _____
3. Is the patient currently being treated with the requested medication? ☐ Yes ☐ No
4. If requesting a self-administered medication, has the patient tried and failed two preferred products (Enbrel, Humira, Simponi, Stelara) or have a contraindication to their use (preferred products will vary between diagnosis)? ☐ Yes ☐ No
   If yes, what is the contraindication? _____
5. Please indicate the following lab values and the date they were last measured.
   a. C-reactive protein level:..... _____ Date: _____
   b. Erythrocyte Sedimentation Rate:.... _____ Date: _____
   c. Rheumatoid Factor:..... _____ Date: _____
   d. Patient weight:..... _____ Date: _____

Initial Authorization

1. Is the patient currently being treated with methotrexate? ☐ Yes ☐ No
   If yes, how long has patient been on therapy? _____
   If no, please explain: _____
2. Please list all medications the patient has previously tried and failed for treatment for this diagnosis: _____
3. Is the requested medication within the product dosing guidelines for the rheumatic disorder diagnosis above? ☐ Yes ☐ No
   If dosing is not within the dosing guidelines, please submit clinical documentation (i.e. clinic notes) of failure of medication when dosed within the guidelines.

3. Is the requested medication within the product dosing guidelines for the rheumatic disorder diagnosis above? ☐ Yes ☐ No
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Renewal Section

1. Have the patient's symptoms improved since the initiation of biologic therapy? ☐ Yes ☐ No
2. Has the patient had improved physical function since the initiation of biologic therapy? ☐ Yes ☐ No
3. Has therapy inhibited structural damage progression since the initiation of biologic therapy? ☐ Yes ☐ No

Please fax or mail this form to:
Prime Therapeutics
Pharmacy Department - UM
PO Box 3248
Omaha, NE 68180-0001

Toll Free Fax: 877-232-6726
Phone: 877-999-2374

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Plaque Psoriasis - Preauthorization Information

Medication Requested (please check):

☐ Cosentyx ☐ Enbrel ☐ Humira ☐ Otezla ☐ Remicade ☐ Stelara ☐ Other: _____

1. Patient's diagnosis to be treated with requested medication (ICD 10 code): _____
2. Dosing regimen of requested medication (example: 40mg subcutaneously every other week): _____
3. Is the patient currently being treated with the requested medication? ☐ Yes ☐ No
4. If requesting a self-administered medication, has the patient tried and failed two preferred products (Enbrel, Humira, Stelara) or have a contraindication to their use? ☐ Yes ☐ No
   If yes, what is the contraindication? _____
5. Patient weight: _____ Date: _____

Initial Authorization

1. What is the patient's body surface area (BSA) involvement? _____ %
2. Is the psoriasis causing significant functional disability? ☐ Yes ☐ No
3. Please list all medications the patient has previously tried and failed for treatment of this diagnosis: _____
4. Does the patient have any contraindications to topical or systemic antipsoriatic agents? ☐ Yes ☐ No
   If yes, please list contraindication(s): _____
5. Is the requested medication within the product dosing guidelines for psoriasis? ☐ Yes ☐ No
   If dosing is not within the dosing guidelines, please submit clinical documentation (i.e. clinic notes) of failure of medication when dosed within the guidelines.

Renewal Section

1. Have the patient's symptoms improved since the initiation of biologic therapy? ☐ Yes ☐ No
2. What is the patient's body surface area (BSA) involvement since therapy initiation? _____ %

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Gastrointestinal Disorders - Preauthorization Information

Medication Requested (please check):

☐ Cimzia ☐ Entyvio ☐ Humira ☐ Remicade ☐ Simponi ☐ Other: _____

1. Patient's diagnosis to be treated with requested medication (ICD 10 code): _____
2. Dosing regimen of requested medication (example: 40mg subcutaneously every other week): _____
3. Is the patient currently being treated with the requested medication? ☐ Yes ☐ No
4. If requesting a self-administered medication, has the patient tried and failed Humira and Simponi or have a contraindication to their use (preferred products will vary between diagnosis)? ☐ Yes ☐ No
   If yes, what is the contraindication? _____
5. Patient weight: _____ Date: _____

Initial Authorization

1. Approximately how many flares per year does the patient currently experience: _____
2. Please list all medications the patient has previously tried and failed for treatment of this diagnosis: _____
3. Does the patient have any contraindications to conventional oral therapy? ☐ Yes ☐ No
   If yes, what is the contraindication? _____
4. Is the requested medication within the product dosing guidelines for gastrointestinal disorder listed above? ☐ Yes ☐ No
   If dosing is not within the dosing guidelines, please submit clinical documentation (i.e. clinic notes) of failure of medication when dosed within the guidelines.

Renewal Section

1. Have the patient's symptoms improved since the initiation of biologic therapy? ☐ Yes ☐ No
2. Approximately how many flares or disease breakthrough episodes per year does the patient currently experience? _____

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