

If the following information is not complete, correct, or legible, the SA process can be delayed.

Please use one form per member.

**MEMBER INFORMATION**

Last Name:

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First Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Medicaid ID Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Date of Birth:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Gender:  Male  Female

Weight in Kilograms: \_\_\_\_\_

**PRESCRIBER INFORMATION**

Last Name:

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First Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

NPI Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Phone Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Fax Number:

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**DRUG INFORMATION**

Drug Name/Form: \_\_\_\_\_

Strength: \_\_\_\_\_

Dosing Frequency: \_\_\_\_\_

Length of Therapy: \_\_\_\_\_

Quantity per Day: \_\_\_\_\_

Preferred drugs Enbrel® or Humira® do not require a SA.

All Non-Preferred drugs listed below require a SA:

- |                                   |                                   |                                    |                                    |                                      |
|-----------------------------------|-----------------------------------|------------------------------------|------------------------------------|--------------------------------------|
| <input type="checkbox"/> Actemra® | <input type="checkbox"/> Cimzia®  | <input type="checkbox"/> Cosentyx™ | <input type="checkbox"/> Dupixent® | <input type="checkbox"/> Entyvio®    |
| <input type="checkbox"/> Ilaris®  | <input type="checkbox"/> Ilumya™  | <input type="checkbox"/> Kevzara®  | <input type="checkbox"/> Kineret®  | <input type="checkbox"/> Olumiant®   |
| <input type="checkbox"/> Orencia® | <input type="checkbox"/> Otezla®  | <input type="checkbox"/> Otrexup®  | <input type="checkbox"/> Rasuvo™   | <input type="checkbox"/> Remicade®   |
| <input type="checkbox"/> Siliq®   | <input type="checkbox"/> Simponi® | <input type="checkbox"/> Skyrizi®  | <input type="checkbox"/> Stelara®  | <input type="checkbox"/> Taltz®      |
| <input type="checkbox"/> Tremfya™ | <input type="checkbox"/> Trexall® | <input type="checkbox"/> Xatmep™   | <input type="checkbox"/> Xeljanz®  | <input type="checkbox"/> Xeljanz® XR |

(Form continued on next page.)

Magellan Complete Care of Virginia CCC Plus website: [www.mccofva.com](http://www.mccofva.com)

Member's Last Name:

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Member's First Name:

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**DIAGNOSIS AND MEDICAL INFORMATION**

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Does the member meet the following criteria?

1. Diagnosis (*check all that apply*):

- Rheumatoid Arthritis (RA)
- Juvenile Idiopathic Arthritis (JIA)
- Ankylosing Spondylitis (AS)
- Plaque Psoriasis (PsO)
- Polyarticular juvenile idiopathic arthritis (pJIA)
- Disease is classified as moderate to severe
- Diagnosis not listed above: \_\_\_\_\_
- Adult Crohn's disease (CD)
- Psoriatic arthritis (PsA)
- Ulcerative Colitis (UC)
- Pediatric Crohn's Disease
- Hidradenitis Suppurativa (HS)
- Uveitis (UV)

2. Therapeutic failure to oral methotrexate?

- Yes
- No
- N/A

3. Therapeutic failure to one of the preferred agents?

- Yes
- No

a. Please provide details of failure below:

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4. **Medical Necessity** (Provide clinical evidence that supports the use of the requested medication):

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**Prescriber Signature (Required)**

**Date**

By signature, the Physician confirms the above information is accurate and verifiable by member records.

**Please include ALL requested information; Incomplete forms will delay the SA process.**

Submission of documentation does NOT guarantee coverage by the Department of Medical Assistance Services.

The completed form may be faxed to **1-800-922-3986**, phoned to **1-800-424-4524 (TTY 711)** or mailed to:

**Magellan Rx Management Prior Authorization Program**

**c/o Magellan Health, Inc.**

**11013 West Broad Street**

**Glen Allen, VA 23060**

**Magellan Complete Care of Virginia CCC Plus website:** [www.mccofva.com](http://www.mccofva.com)