

Service Authorization (SA) Form

Cytokine and CAM Antagonists and Related Agents

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:

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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.)

Member's Last Name:

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Member's First Name:

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DIAGNOSIS AND MEDICAL INFORMATION

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:

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

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 **1-800-424-7581**, phoned to **1-800-424-4518 (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 – Medallion 4.0 website: www.mccofva.com