Aetna Better Health®

Fax completed prior authorization request form to 844-802-1412 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 https://www.aetnabetterhealth.com/Illinois-medicaid

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 Agents:	☐ Humira	☐ Enbrel	☐ Cimzia	☐ Xeljanz	☐ Xeljanz XR
Non-Preferred Agents:	☐ Actemra	☐ Arcalyst	☐ Cosentyx	☐ Taltz	☐ Skyrizi
	☐ Ilaris	☐ Ilumya	☐ Kineret	☐ Siliq	☐ Simponi Aria
	☐ Orencia	☐ Renflexis	☐ Tremfya	☐ Tysabri	☐ Inflectra
	☐ Olumiant	☐ Remicade	☐ Simponi	☐ Stelara	
	☐ Other, please specify:				
Medication request is NOT for an FDA- approved, or compendia-supported diagnosis (circle one): Yes ☐ No ☐	Diagnosis:	☐ ICD-10 Code:		
Are there any contraindications to formulary medications? (if yes, specify):	☐ Yes	☐ No	☐ New request	☐ Continuation of therapy
Directions for Use:	Strength:	Dosage Form:		
	Quantity:	Day Supply:	Duration of Therapy/Use:	
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 - ALL Agents and Indications:				
Is member on another Cytokine or Cell Adhesion Molecule (CAM) Antagonist?	☐ Yes	☐ No		
Is request for an Anti-Tumor Necrosis Factor?	☐ Yes	☐ No	Does member have NYHA class III or IV CHF?	☐ Yes	☐ No	☐ N/A

Is request for Anti-Tumor Necrosis Factors such as Stelara, Xeljanz, Xeljanz XR, Kineret, Actemra, Ilaris OR Orencia?						☐ Yes	☐ No	
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, is member receiving appropriate antiviral treatment?			☐ Yes	☐ No	☐ N/A			
Was member evaluated AND given appropriate vaccinations, as recommended per CDC for risk factors?						☐ Yes	☐ No	
Was member screened for TB?	☐ Yes	☐ No	If screening was positive for latent TB, was treatment received for latent TB?		☐ Yes	☐ No	☐ N/A	
Is request for Entyvio or Tysabri?	☐ Yes	☐ No	Is use Monotherapy AND not in combination with antineoplastic, immunosuppressive OR immunomodulating agents (AZA, 6-MP, cyclosporine, MTX, TNF inhibitors)		☐ Yes	☐ No	☐ N/A	
Additional Criteria Based on Indication:								
☐ **Rheumatoid Arthritis**								
Was there inadequate response to 3-month trial of MTX?	☐ Yes	☐ No	Was there intolerance OR contraindication to MTX?		☐ Yes	☐ No		
Were SSZ, LEF or HCQ used due to intolerance OR contraindication to MTX?	☐ Yes	☐ No	Will requested medication be used concurrently with MTX or another non-biologic DMARD such as SSZ, LEF or HCQ?		☐ Yes	☐ No		
☐ **Systemic Juvenile Idiopathic Arthritis**								
Does member have ACTIVE SYSTEMIC FEATURES such as fever, evanescent rash, lymphadenopathy, hepatomegaly, splenomegaly OR serositis? (circle one): ☐ Yes ☐ No			Is synovitis in ONE OR MORE JOINTS despite 3 months treatment with MTX OR LEF? (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 3 months treatment with MTX OR LEF							
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 MTX or LEF (circle one): ☐ Yes ☐ No					
☐ **Polyarticular Juvenile Idiopathic Arthritis**								
Was there inadequate response to 3-months trial with MTX?			☐ Yes	☐ No				
Was there an intolerance OR contraindication to MTX?	☐ Yes	☐ No	☐ N/A	Was there trial with SSZ OR LEF for 3 months?	☐ Yes	☐ No	☐ N/A	
☐ **Oligoarticular Juvenile Idiopathic Arthritis**								
Is disease duration > 6 months?	☐ Yes	☐ No	Was there documented inadequate response OR intolerable side effect with 2 NSAIDs?	☐ Yes, indicate drug _____	☐ No			
Did member have contraindication to NSAIDs?	☐ Yes	☐ No	☐ N/A					
Did member have inadequate response OR intolerable side effect to 3-month trial with MTX?	☐ Yes	☐ No	Was there documented trial of LEF or SSZ for 3 months?	☐ Yes	☐ No	☐ N/A		
☐ **Cryopyrin-Associated Periodic Syndromes**								
Indicate if ONE of the following subtypes is present:	☐ Familial Cold Auto Inflammatory Syndrome		☐ Muckle-Wells syndrome		☐ Neonatal onset multi-system inflammatory disease			
Was there 3-months trial with Kineret?			☐ Yes	☐ No				
☐ **Familial Mediterranean Fever**								
Was there inadequate response, intolerance OR contraindication to colchicine at MAX indicated dose?					☐ Yes	☐ No		
☐ **Giant Cell Arteritis**								

Was there inadequate response with glucocorticoids (for example prednisone, methylprednisolone?	☐ Yes	☐ No	Was there intolerance OR contraindication to glucocorticoids?			☐ Yes	☐ No
If member had intolerance OR contraindication to glucocorticoids, was there a TRIAL with MTX OR cyclophosphamide?	☐ Yes	☐ No	☐ N/A	Will medication be used in combination with tapering course of glucocorticoids		☐ Yes	☐ No

☐ Ankylosing Spondylitis								
Was there inadequate response to ONE-month trial of TWO NSAIDs?	☐ Yes	☐ No	Is there contraindication OR intolerance to oral NSAIDs?		☐ Yes	☐ No	☐ N/A	

☐ Psoriatic Arthritis								
Does member have ACTIVE Psoriatic Arthritis?	☐ Yes	☐ No	Was there inadequate response to 3-months trial with MTX?				☐ Yes	☐ No
Was there intolerance OR contraindication to MTX?	☐ Yes	☐ No	☐ N/A	Was there 3-month trial of SSZ OR LEF?			☐ Yes	☐ No
Is disease predominantly AXIAL OR ACTIVE ENTHESITIS / DACTYLITIS?							☐ Yes	☐ No
Was there inadequate response to ONE-month trial of 2 NSAIDs?	☐ Yes	☐ No	Was there contraindication OR intolerance to oral NSAIDs?		☐ Yes	☐ No	☐ N/A	

☐ Plaque Psoriasis								
Was there inadequate response to MTX OR cyclosporine for ≥3 months?	☐ Yes	☐ No	Was there intolerance OR contraindication to MTX OR cyclosporine for ≥3 months?		☐ Yes	☐ No	☐ N/A	
Is >10% BSA affected?	☐ Yes	☐ No	Is <10% BSA affected BUT involves sensitive areas such as hands, feet, face OR genitals?				☐ Yes	☐ No
Is Psoriasis Area and Severity Index score >10?	☐ Yes	☐ No	Was phototherapy PUVA, UVB ineffective?				☐ Yes	☐ No
For Siliq only:	Does member have history of prior suicide attempt, bipolar disorder OR depressive disorder?						☐ Yes	☐ No
	Was a mental health evaluation completed by prescriber OR psychiatrist?						☐ Yes	☐ No

☐ Ulcerative Colitis			
☐ STEROID DEPENDENT	A relapse occurred within 3-months of stopping glucocorticoids (circle one): ☐ Yes ☐ No	There is Inability to taper steroids to acceptable dose after 3 months W/O having symptom recurrence:(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	

☐ Crohn's Disease			
☐ STEROID DEPENDENT	A relapse occurred within 3-months of stopping glucocorticoids (circle one): ☐ Yes ☐ No	There was inadequate response OR intolerable side effect, with 3-month trial of 6-MP OR AZA OR injectable MTX (circle one): ☐ Yes ☐ No	
	There is inability to taper steroids to acceptable dose after 3 months W/O having symptom recurrence (circle one): ☐ Yes ☐ No	There was contraindication to 6-MP, AZA, AND injectable MTX (circle one): ☐ Yes ☐ No	
☐ STEROID REFRACTORY	There was inadequate response OR intolerable side effect to IV glucocorticoids after 7-10 days (circle one): ☐ Yes ☐ No	There was inadequate response OR intolerable side effect to oral prednisone ≥40mg per day after 30 days (circle one): ☐ Yes ☐ No	

☐ Hidradenitis Suppurativa - Acne Inversa								
Does member have moderate to severe disease (Hurley stage II-III)?	☐ Yes	☐ No	Was there trial and failure of 90-day treatment with oral antibiotics such as doxycycline, minocycline OR clindamycin with rifampin?				☐ Yes	☐ No

☐ Uveitis						
Was intermediate, posterior OR pan uveitis caused by infection?	☐ Yes	☐ No	There was inadequate response OR intolerable side effect with following:	☐ cyclosporine	☐ tacrolimus	☐ Corticosteroids
				☐ MTX	☐ AZA	☐ MMF
Are medications such as corticosteroids, MTX, AZA, MMF, cyclosporine, AND tacrolimus NOT appropriate?						☐ Yes ☐ No

☐ Cytokine Release Syndrome		
Is diagnosis grade 3 OR 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 866-329-4701 to check the status of a request.