Prior Authorization Form

GEHA FEDERAL - STANDARD OPTION

Autoimmune Conditions (FA-PA)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**.
Please contact CVS/Caremark at **1-855-240-0536** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Autoimmune Conditions (FA-PA).

Drug Name
(specify drug) _____

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1.	Is this a request for continuation of therapy with the requested product?	Y N
2.	Is the patient currently receiving the requested product through samples or a manufacturer's patient assistance program? If unknown, answer Yes.	Y N
3.	Is the request for Actemra, Kineret, or Xeljanz/Xeljanz XR?	Y N
4.	Is the requested product prescribed for an ADULT patient (18 years of age or older) with rheumatoid arthritis?	Y N
5.	Can the patient's treatment be switched to a preferred product? These are the preferred products for which coverage is provided for treatment of the following	Y N

	conditions: Rheumatoid arthritis: ENBREL, HUMIRA, KEVZARA		
6.	Does the patient have one of the following documented clinical reasons to avoid Enbrel and Humira: a. History of demyelinating disorder \ b. History of congestive heart failure \ c. History of hepatitis B virus infection \ d. Autoantibody formation/lupus-like syndrome \ e. Risk of lymphoma ACTION REQUIRED: IF 'YES', ATTACH SUPPORTING CHART NOTE(S).	Y N	
7.	Has the patient had a documented inadequate response or intolerable adverse event with the non-TNF preferred product Kevzara? ACTION REQUIRED: IF 'YES', ATTACH SUPPORTING CHART NOTE(S).	Y N	
8.	Has the patient had a documented inadequate response or intolerable adverse event with all of the preferred products (Enbrel, Humira, and Kevzara)? ACTION REQUIRED: IF 'YES', ATTACH SUPPORTING CHART NOTE(S).	Y N	
9.	Is the request for Cimzia, Orencia, or Simponi?	Y N	
10.	Is the requested product prescribed for an ADULT patient (18 years of age or older) with one of the following indications: Ankylosing spondylitis \ Psoriatic arthritis \ Rheumatoid arthritis \ Crohn's disease/ulcerative colitis	Y N	
11.	Can the patient's treatment be switched to a preferred product? These are the preferred products for which coverage is provided for treatment of the following conditions: Ankylosing spondylitis: COSENTYX, ENBREL, HUMIRA \ Psoriatic arthritis: COSENTYX, ENBREL, HUMIRA, OTEZLA, STELARA \ Rheumatoid arthritis: ENBREL, HUMIRA, KEVZARA \ Crohn's disease/ulcerative colitis: HUMIRA	Y N	
12.	Does the patient have a diagnosis of ankylosing spondylitis?	Y N	
13.	Does the patient have one of the following documented clinical reasons to avoid Enbrel and Humira: a. History of demyelinating disorder \ b. History of congestive heart failure \ c. History of hepatitis B virus infection \ d. Autoantibody formation/lupus-like syndrome \ e. Risk of lymphoma ACTION REQUIRED: IF 'YES', ATTACH SUPPORTING CHART NOTE(S).	Y N	
14.	Has the patient had a documented inadequate response or intolerable adverse event with the non-TNF preferred product Cosentyx? ACTION REQUIRED: IF 'YES', ATTACH SUPPORTING CHART NOTE(S).	Y N	
15.	Has the patient had a documented inadequate response or intolerable adverse event with all of the preferred products (Cosentyx, Enbrel, and Humira)? ACTION REQUIRED: IF 'YES', ATTACH SUPPORTING CHART NOTE(S).	Y N	

16. Does the patient have a diagnosis of psoriatic arthritis?	Y N	
17. Does the patient have one of the following documented clinical reasons to avoid Enbrel and Humira: a. History of demyelinating disorder \ b. History of congestive heart failure \ c. History of hepatitis B virus infection \ d. Autoantibody formation/lupus-like syndrome \ e. Risk of lymphoma ACTION REQUIRED: IF 'YES', ATTACH SUPPORTING CHART NOTE(S).	Y N	
18. Has the patient had a documented inadequate response or intolerable adverse event with all of the non-TNF preferred products (Cosentyx, Otezla, and Stelara)? ACTION REQUIRED: IF 'YES', ATTACH SUPPORTING CHART NOTE(S).	Y N	
19. Has the patient had a documented inadequate response or intolerable adverse event with all of the preferred products (Cosentyx, Enbrel, Humira, Otezla, and Stelara)? ACTION REQUIRED: IF 'YES', ATTACH SUPPORTING CHART NOTE(S).	Y N	
20. Does the patient have a diagnosis of rheumatoid arthritis?	Y N	
21. Does the patient have one of the following documented clinical reasons to avoid Enbrel and Humira: a. History of demyelinating disorder \ b. History of congestive heart failure \ c. History of hepatitis B virus infection \ d. Autoantibody formation/lupus-like syndrome \ e. Risk of lymphoma ACTION REQUIRED: IF 'YES', ATTACH SUPPORTING CHART NOTE(S).	Y N	
22. Has the patient had a documented inadequate response or intolerable adverse event with all the non-TNF preferred product Kevzara? ACTION REQUIRED: IF 'YES', ATTACH SUPPORTING CHART NOTE(S).	Y N	
23. Has the patient had a documented inadequate response or intolerable adverse event with all of the preferred products (Enbrel, Humira, and Kevzara)? ACTION REQUIRED: IF 'YES', ATTACH SUPPORTING CHART NOTE(S).	Y N	
24. Does the patient have a diagnosis of Crohn's disease or ulcerative colitis?	Y N	
25. Has the patient had a documented inadequate response or intolerable adverse event with Humira? ACTION REQUIRED: IF 'YES', ATTACH SUPPORTING CHART NOTE(S).	Y N	
26. Does the patient have one of the following documented clinical reasons to avoid Humira: a. History of demyelinating disorder \ b. History of congestive heart failure \ c. History of hepatitis B virus infection \ d. Autoantibody formation/lupus-like syndrome \ e. Risk of lymphoma ACTION REQUIRED: IF 'YES', ATTACH SUPPORTING CHART NOTE(S).	Y N	

27. Is the request for Entyvio or Stelara?	Y N	
28. Is the requested product prescribed for an ADULT patient (18 years of age or older) with Crohn's disease or ulcerative colitis?	Y N	
29. Can the patient's treatment be switched to the preferred product? These are the preferred products for which coverage is provided for treatment of the following conditions: Crohn's disease or ulcerative colitis: HUMIRA	Y N	
30. Has the patient had a documented inadequate response or intolerable adverse event with Humira? ACTION REQUIRED: IF 'YES', ATTACH SUPPORTING CHART NOTE(S).	Y N	
31. Does the patient have one of the following documented clinical reasons to avoid Humira: a. History of demyelinating disorder \ b. History of congestive heart failure \ c. History of hepatitis B virus infection \ d. Autoantibody formation/lupus-like syndrome \ e. Risk of lymphoma ACTION REQUIRED: IF 'YES', ATTACH SUPPORTING CHART NOTE(S).	Y N	
32. Is the request for Siliq, Taltz, or Tremfya?	Y N	
33. Is the requested product prescribed for an ADULT patient (18 years of age or older) with plaque psoriasis?	Y N	
34. Can the patient's treatment be switched to a preferred product? These are the preferred products for which coverage is provided for treatment of the following condition: Plaque psoriasis: COSENTYX, ENBREL, HUMIRA, OTEZLA, STELARA	Y N	
35. Does the patient have one of the following documented clinical reasons to avoid Enbrel and Humira: a. History of demyelinating disorder \ b. History of congestive heart failure \ c. History of hepatitis B virus infection \ d. Autoantibody formation/lupus-like syndrome \ e. Risk of lymphoma ACTION REQUIRED: IF 'YES', ATTACH SUPPORTING CHART NOTE(S).	Y N	
36. Has the patient had a documented inadequate response or intolerable adverse event with all of the non-TNF preferred products (Cosentyx, Otezla, and Stelara)? ACTION REQUIRED: IF 'YES', ATTACH SUPPORTING CHART NOTE(S).	Y N	
37. Has the patient had a documented inadequate response or intolerable adverse event with all of the preferred products (Cosentyx, Enbrel, Humira, Otezla, and Stelara)? ACTION REQUIRED: IF 'YES', ATTACH SUPPORTING CHART NOTE(S).	Y N	
38. Is the request for Inflectra or Renflexis?	Y N	
39. Can the patient's treatment be switched to a preferred product? These are the preferred products for which coverage is provided for treatment of the following	Y N	

conditions: Ankylosing spondylitis: COSENTYX, ENBREL, HUMIRA \ Plaque psoriasis/psoriatic arthritis: COSENTYX, ENBREL, HUMIRA, OTEZLA, STELARA \ Rheumatoid arthritis: ENBREL, HUMIRA, KEVZARA \ Crohn's disease/ulcerative colitis: HUMIRA		
40. Is the requested product prescribed for an ADULT patient (18 years of age or older) with ankylosing spondylitis?	Y N	
41. Has the patient had a documented inadequate response or intolerable adverse event with all of the preferred products (Cosentyx, Enbrel, and Humira)? ACTION REQUIRED: IF 'YES', ATTACH SUPPORTING CHART NOTE(S).	Y N	
42. Is the requested product prescribed for an ADULT patient (18 years of age or older) with plaque psoriasis or psoriatic arthritis?	Y N	
43. Has the patient had a documented inadequate response or intolerable adverse event with all of the preferred products (Cosentyx, Enbrel, Humira, Otezla, and Stelara)? ACTION REQUIRED: IF 'YES', ATTACH SUPPORTING CHART NOTE(S).	Y N	
44. Is the requested product prescribed for an ADULT patient (18 years of age or older) with rheumatoid arthritis?	Y N	
45. Has the patient had a documented inadequate response or intolerable adverse event with all of the preferred products (Enbrel, Humira, and Kevzara)? ACTION REQUIRED: IF 'YES', ATTACH SUPPORTING CHART NOTE(S).	Y N	
46. Is the requested product prescribed for an ADULT patient (18 years of age or older) with Crohn's disease or ulcerative colitis?	Y N	
47. Has the patient had a documented inadequate response or intolerable adverse event with Humira? ACTION REQUIRED: IF 'YES', ATTACH SUPPORTING CHART NOTE(S).	Y N	

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date