

Anthem UM Tumor Necrosis Factor PreDetermination of Medical Benefits Services, Inc. Antagonists [Enbrel® (etanercept); Humira® (adalimumab); Remicade® (infliximab)]

Complete form in its entirety and fax to UM Call Center at (404) 848-2448

Click on grey boxes to type	Request Date: / /
<input type="checkbox"/> Initial Authorization Request	<input type="checkbox"/> Subsequent Request; List Prior Auth Ref #:
<input type="checkbox"/> Medication(s) is to be dispensed, delivered, and managed by PrecisionRx Specialty Solutions fax: (800-824-2642)	

1. PATIENT INFORMATION			
Patient Last Name	Patient First Name	Anthem Member ID Number	Patient DOB / /
Contact Phone Number () -	Primary Diagnosis	ICD-9 Code(s)	Patient's Weight (lbs) Date: _____
2. PHYSICIAN INFORMATION			
Physician Last Name	Physician First Name	Physician DEA or NPI Number	Physician Tax ID
Address		City	State Zip Code
Office Phone Number () -	Office Fax Number () -	Office Contact Name and ext.	Physician Specialty
3. MEDICATION INFORMATION – This section serves as the active prescription – signature required.			
Drug Name	HCPCS or CPT Code(s)	Strength / Dose	
Direction for Use (SIG)			
Date patient is scheduled to be treated (need by date) / /	Service From Date / /	Service Thru Date / /	Number of Refills
Ship Medication to: <input type="checkbox"/> MD Office <input type="checkbox"/> Patient's Home <input type="checkbox"/> Other: (please specify)			
4. MEDICATION	5. DOSE	6. FREQUENCY	7. DURATION
<input type="checkbox"/> Enbrel (J1438) <input type="checkbox"/> Humira (J0135) <input type="checkbox"/> Remicade (J1745)			

8. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY	
NOTE: To avoid delays , please complete this form in its entirety. Incomplete forms that are missing pertinent information will be pended. Please provide ALL supporting lab results, progress notes, etc.	
FOR ENBREL (ETANERCEPT) USE	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Did patient have a tuberculin skin test to rule out latent tuberculosis? Please provide test result and date: _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have any active infections?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Will Enbrel be used in combination with any other TNFs or Kineret?
(1) Adult Rheumatoid Arthritis (RA)	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Patient is ≥ 18 y.o. who has moderately to severely active RA, AND
<input type="checkbox"/> Yes <input type="checkbox"/> No	Patient had an inadequate response to one or more DMARDs Please list DMARDs tried and date:

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(2) Juvenile Rheumatoid Arthritis

- Yes No Patient has moderately to severely active polyarticular-course juvenile RA and had an inadequate response to one or more DMARDs
Please list DMARDs tried and date: _____

(3) Adult Plaque Psoriasis

- Yes No Patient is ≥ 18 y.o. who has chronic moderate to severe plaque psoriasis; **AND**
 Yes No Treatment resistant disease covering > 10% BSA; **OR**
 Yes No Less than or equal to 10% BSA involving sensitive areas or areas that would significantly impact daily function (e.g. palms, soles of feet, head/neck, or genitalia).
 Yes No Patient is currently receiving systemic therapies, (e.g. MTX, acitretin, cyclosporine), or phototherapy
 Yes No Patient has a h/o of recurrent infections, current chronic infection, or positive tuberculin skin test
 Yes No Patient had a systemic malignancy within the last 5 years

(4) Adult Psoriatic Arthritis

- Yes No Patient is ≥ 18 y.o and has active arthritis with at least 3 swollen and 3 tender joints, **AND**
 Yes No There is presence of plaque psoriasis with a qualifying target lesion of at least 2 cm in diameter, **AND**
 Yes No Arthritis in any of the following distributions: **AND**
 distal interphalangeal joints arthritis multilans Other _____
 asymmetric arthritis polyarticular arthritis without rheumatoid nodule _____
 Yes No Patient has tried and failed or has a contraindication to DMARDs, specifically MTX or sulfasalazine.
Please list DMARDs tried and date: _____

(5) Active Adult Ankylosing Spondylitis

- Yes No Patient is ≥ 18 y.o and has active ankylosing spondylitis, **AND**
 Yes No Patient has tried and failed or has a contraindication to conventional therapies, e.g. NSAIDs, sulfasalazine, or MTX
Please list therapy (ies) tried and date: _____

(6) Other Arthritis

- Yes No Patient has reactive arthritis
 Yes No Patient is ≥ 18 y.o. and has arthritis associated with inflammatory bowel disease

FOR HUMIRA (ALALIMUMAB) USE

- Yes No Did the patient have a tuberculin skin test to rule out latent tuberculosis?
Please provide test result and date:
 Yes No Does the patient have any active infections?
 Yes No Will Humira be used in combination with any other TNFs or Kineret?

(1) Rheumatoid Arthritis (RA)

- Yes No Patient has moderately to severely active RA, **AND**
 Yes No Patient had an inadequate response to one or more DMARDs
Please list DMARDs tried and date: _____

(2) Adult Psoriatic Arthritis

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- Yes No Patient is ≥ 18 y.o and has active arthritis with at least 3 swollen and 3 tender joints, **AND**
- Yes No There is presence of plaque psoriasis with a qualifying target lesion of at least 2 cm in diameter, **AND**
- Yes No Arthritis in any of the following distributions: **AND**
- distal interphalangeal joints arthritis multilans Other
- asymmetric arthritis polyarticular arthritis without rheumatoid nodule _____
- Yes No Patient has tried and failed or has a contraindication to DMARDs, specifically MTX or sulfasalazine.
Please list DMARDs tried and date: _____

(3) Active Adult Ankylosing Spondylitis

- Yes No Patient is ≥ 18 y.o and has active ankylosing spondylitis, **AND**
- Yes No Patient has tried and failed or has a contraindication to conventional therapies, e.g. NSAIDs, sulfasalazine, or MTX
Please list therapy (ies) tried and date: _____

(4) Crohn's Disease

- Yes No Patient is ≥ 18 y.o and has moderately to severely active Crohn's disease, **AND**
- Yes No Patient has tried and failed conventional therapy (ies) (e.g. NSAIDs, sulfasalazine, or MTX, **AND**
Please list therapy (ies) tried and date: _____
- Yes No Patient has not been previously treated with a TNF agent, **OR**
- Yes No Patient has previously been treated with Remicade but has lost response to or is intolerant to Remicade

FOR REMICADE (INFLIXIMAB) USE

- Yes No Did the patient have a tuberculin skin test to rule out latent tuberculosis?
Please provide test result and date: _____
- Yes No Does the patient have any active infections?
- Yes No Will Remicade be used in combination with any other TNFs or Kineret?

(1) Rheumatoid Arthritis (RA)

- Yes No Patient is ≥ 18 y.o. and has moderately to severely active RA, **AND**
- Yes No Patient had an inadequate response to one or more DMARDs
Please list DMARDs tried and date: _____

(2) Adult Plaque Psoriasis

- Yes No Patient is ≥ 18 y.o. who has chronic severe (i.e. extensive or disabling) plaque psoriasis; **AND**
- Yes No Treatment resistant disease covering > 10% BSA; **OR**
- Yes No Less than or equal to 10% BSA involving sensitive areas or areas that would significantly impact daily function (e.g. palms, soles of feet, head/neck, or genitalia).
- Yes No Patient is currently receiving systemic therapies, (e.g. MTX, acitretin, cyclosporine), or phototherapy
- Yes No Patient has a h/o of recurrent infections, current chronic infection, or positive tuberculin skin test

(3) Adult Psoriatic Arthritis

- Yes No Patient is ≥ 18 y.o and has active arthritis with at least 5 swollen and 5 tender joints, **AND**
- Yes No There is presence of plaque psoriasis with a qualifying target lesion of at least 2 cm in diameter, **AND**
- Yes No Arthritis in any of the following distributions: **AND**
- distal interphalangeal joints arthritis multilans Other
- asymmetric arthritis polyarticular arthritis without _____

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Yes No Patient has tried and failed or has a contraindication to DMARDs, specifically MTX or sulfasalazine.
Please list DMARDs tried and date: _____

(4) Active Adult Ankylosing Spondylitis

Yes No Patient is ≥ 18 y.o and has active ankylosing spondylitis, **AND**
 Yes No Patient has tried and failed or has a contraindication to conventional therapies, e.g. NSAIDs, sulfasalazine, or MTX
 Please list therapy (ies) tried and date: _____

(5) Crohn's Disease

Yes No Patient has moderately to severely active Crohn's disease with one or more of the following symptoms, **AND**

<input type="checkbox"/> abdominal pain	<input type="checkbox"/> intestinal obstruction	<input type="checkbox"/> megacolon
<input type="checkbox"/> bleeding	<input type="checkbox"/> perianal disease	<input type="checkbox"/> extra-intestinal manifestations (arthritis, uveitis, iritis, pyoderma gangrenosum, spondylitis, erythema nodosum, or internal fistulae)
<input type="checkbox"/> diarrhea	<input type="checkbox"/> weight loss	

Yes No Patient has tried and failed conventional therapy (ies) (e.g. oral mesalamine, oral corticosteroids, 6-mercaptopurine, or azathioprine), **OR**
 Please list therapy (ies) tried and date: _____

Yes No Patient has fistulizing Crohn's disease, with draining enterocutaneous and rectovaginal fistulas, for at least 3 months in duration, **OR**

Yes No Patient has fistulizing or moderately to severely active Crohn's disease who has responded to prior Remicade treatments

(6) Ulcerative Colitis

Yes No Patient has moderately to severely active ulcerative colitis, **AND**

Yes No Patient has tried and failed conventional therapy (ies)
 Please list therapy (ies) tried and date: _____

(7) Other Arthritis

Yes No Patient has reactive arthritis

Yes No Patient is ≥ 18 y.o. and has arthritis associated with inflammatory bowel disease

(8) Other (Please submit all supporting documents including labs, progress notes, imaging, etc., for review.)

9. PHYSICIAN SIGNATURE

Prescriber's or Authorized Representative's Signature:

Date: ____ / ____ / ____

Prior Authorization is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions.

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Medical Policy Reference can be found at: www.bcbsga.com

Anthem UM Services, Inc. an independent company and is the licensed utilization review agent that performs utilization management services on behalf of your health benefit plan or the administrator of your health benefit plan.