GHP Family Pharmacy Customer Service
100 N. Academy Ave.
Danville, PA 17822
Tel. • 855•552•6028 PA Relay 711 GeisingerHealthPlan.com

Geisinger

CYTOKINE AND CAM ANTAGONISTS PRIOR AUTHORIZATION FORM *(form effective 2/17/2022)*

Prior authorization guidelines for **Cytokine and CAM Antagonists** and **Quantity Limits/Daily Dose Limits** are available on Geisinger Health Plan's website at https://healthplan.geisinger.org/pharmacy/pharmacy.aspx?strip=true&style=OneGeisinger

☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

STARTER PACK requested (name/strength):		**MAINTENANCE product/packaging requested (name/strength):**	
Quantity per fill:	Refills:	Quantity per fill:	Refills:
Directions:		Directions:	
Diagnosis (*submit documentation*):		Dx code (*required*):	Beneficiary weight:
Is the beneficiary currently being treated with the requested medication?		☐Yes – date of last dose: _____ *Submit documentation.* ☐No	
Is the requested medication prescribed by or in consultation with a specialist (e.g., rheumatologist, dermatologist, gastroenterologist, etc.)?		☐Yes *If prescriber is not a specialist, submit documentation of consultation.* ☐No	

Is the beneficiary using a different Cytokine and CAM Antagonist?
☐Yes
☐No

If Yes to the above question:
☐Will discontinue use of that Cytokine and CAM Antagonist prior to starting the requested Cytokine and CAM Antagonist

OR

☐Has a medical reason for concomitant use of both Cytokine and CAM Antagonists that isa supported by peer-reviewed medical literature or national treatment guidelines,
☐Is dependent on glucocorticoids in addition to a Cytokine and CAM Antagonist to prevent life-threatening complications,
☐Has 2 or more autoimmune or autoinflammatory conditions for which a single Cytokine and CAM Antagonist is not sufficient

GHP Family Pharmacy Customer Service
100 N. Academy Ave.
Danville, PA 17822
Tel. • 855•552•6028 PA Relay 711 GeisingerHealthPlan.com

Geisinger

INITIAL requests

Complete the sections below that are applicable to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.

DRUG

☐ **Requested drug is NON-PREFERRED drug:**
- ☐ Tried and failed or has a contraindication or intolerance to the preferred drugs in this class approved or medically accepted for the beneficiary's condition *(Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*

☐ **Requested drug is OTEZLA (apremilast)** or **SILIQ (brodalumab):**
- ☐ Was evaluated for history of prior suicide attempt, bipolar disorder, or major depressive disorder

DIAGNOSIS

For a Cytokine and CAM Antagonists associated with an increased risk of infection according to the FDA-approved package labeling:
- ☐ screened for hepatitis B (surface antigen, surface antibody, and core antibody)
- ☐ screened for tuberculosis

☐ **Adult-onset Still's disease:**
- ☐ **Has predominantly systemic disease:**
  - ☐ Has steroid-dependent disease
  - ☐ Tried and failed or has a contraindication or intolerance to systemic glucocorticoids
- ☐ **Has predominantly joint disease:**
  - ☐ Tried and failed or has a contraindication or intolerance to conventional DMARDs (eg, MTX)

☐ **Ankylosing spondylitis & non-radiographic axial spondyloarthritis:**
- ☐ Tried and failed a 2-week trial of or has a contraindication or intolerance to 2 different oral NSAIDs

☐ **Atopic dermatitis (eczema):**
- ☐ Tried and failed or has a contraindication or an intolerance to:
  - ☐ For the face or skin folds, low-potency (or higher) topical corticosteroids
  - ☐ For other body areas, a topical corticosteroid with a potency appropriate for the beneficiary's age and affected area(s) of the body
  - ☐ Elidel (pimecrolimus) or Protopic (tacrolimus)
  - ☐ Phototherapy/photochemotherapy (e.g., PUVA, UVB light)
  - ☐ Systemic immunosuppressives (e.g., azathioprine, cyclosporine, methotrexate, mycophenolate)

☐ **Behçet's syndrome:**
- ☐ Has recurrent oral ulcers associated with Behçet's syndrome
- ☐ Tried and failed or has a contraindication or intolerance to a topical corticosteroid (eg, triamcinolone dental paste)
- ☐ Tried and failed a 3-month trial of or has a contraindication or intolerance to colchicine at maximally tolerated doses

☐ **Crohn's disease:**
- ☐ Has moderate-to-severe disease
- ☐ Has disease that is associated with high-risk or poor prognostic features
- ☐ Tried and failed to achieve remission with or has a contraindication or intolerance to an induction course of corticosteroids
- ☐ Tried and failed to maintain remission with or has a contraindication or intolerance to immunomodulators (eg, AZA, 6-MP, MTX)

☐ **Familial Mediterranean fever:**
- ☐ Tried and failed a 3-month trial of or has a contraindication or intolerance to colchicine at maximally tolerated doses

☐ **Giant cell arteritis:**
- ☐ Tried and failed or has a contraindication or intolerance to systemic glucocorticoids
- ☐ Is at high risk for glucocorticoid-related complications
- ☐ Has steroid-dependent disease

GHP Family Pharmacy Customer Service
100 N. Academy Ave.
Danville, PA 17822
Tel. • 855•552•6028 PA Relay 711 GeisingerHealthPlan.com

Geisinger

☐ **Hidradenitis suppurativa (HS):**
- ☐ Has Hurley stage II or stage III disease
- ☐ Is a candidate for or has a history of surgical intervention for HS
- ☐ Tried and failed a 3-month trial of or has a contraindication or intolerance to topical clindamycin
- ☐ Tried and failed or has a contraindication or intolerance to systemic antibiotics (eg, doxycycline, minocycline, tetracycline, clindamycin)

☐ **Juvenile idiopathic arthritis:**
- ☐ Has systemic disease with active systemic features
- ☐ Has disease associated with any of the following:
  - ☐ Positive anti-CCP antibodies
  - ☐ Presence of joint damage
  - ☐ High disease activity
  - ☐ Positive rheumatoid factor
  - ☐ At high risk of disabling joint damage
  - ☐ Involvement of high-risk joints (cervical spine, hip, wrist)
- ☐ Tried and failed a 3-month trial of or has a contraindication or intolerance to conventional DMARDs (eg, MTX)
- ☐ **Has active sacroiliitis and/or enthesitis:**
  - ☐ Tried and failed a 2-week trial of or has a contraindication or intolerance to oral NSAIDs

☐ **Plaque psoriasis:**
- ☐ Has a BSA of ≥ 3% that is affected
- ☐ Has involvement of critical areas of the body (eg, skin folds, face, genitals)
- ☐ Has psoriasis that causes significant disability or impaired physical or mental functioning
- ☐ Tried and failed or has a contraindication or intolerance to topical corticosteroids
- ☐ Tried and failed or has a contraindication or intolerance to non-steroid topical medications (eg, anthralin, calcineurin inhibitor, tazarotene, etc)
- ☐ Tried and failed or has a contraindication or intolerance to ultraviolet light therapy
- ☐ Tried and failed a 3-month trial of or has a contraindication or intolerance to oral systemic medications (eg, MTX, cyclosporine, acitretin)

☐ **Psoriatic arthritis:**
- ☐ Has severe disease
- ☐ Has comorbid moderate-to-severe nail psoriasis
- ☐ Has predominantly axial disease and/or enthesitis
- ☐ **Has predominantly peripheral disease:**
  - ☐ Tried and failed an 8-week trial of or has a contraindication or intolerance to conventional DMARDs (eg, AZA, leflunomide, MTX, SSZ)

☐ **Rheumatoid arthritis:**
- ☐ Tried and failed a 3-month trial of or has a contraindication or intolerance to conventional DMARDs (eg, AZA, leflunomide, MTX, etc)

☐ **Sarcoidosis:**
- ☐ Tried and failed or has a contraindication or intolerance to systemic glucocorticoids
- ☐ Has steroid-dependent disease
- ☐ Tried and failed or has a contraindication or intolerance to a conventional DMARD (eg, AZA, leflunomide, MTX, mycophenolate)

☐ **Ulcerative colitis:**
- ☐ Has moderate-to-severe disease
- ☐ Has disease associated with multiple poor prognostic factors
- ☐ Tried and failed to achieve remission with or has a contraindication or intolerance to an induction course of corticosteroids
- ☐ Tried and failed to maintain remission with or has a contraindication or intolerance to immunomodulators (eg, AZA, cyclosporine, 6-MP, MTX)

☐ **Uveitis (non-infectious):**
- ☐ Has comorbid juvenile idiopathic arthritis
- ☐ Has comorbid Behçet's syndrome
- ☐ Has steroid-dependent disease
- ☐ Tried and failed or has a contraindication or intolerance to systemic, topical, intraocular, or periocular corticosteroids
- ☐ Tried and failed or has a contraindication or intolerance to conventional systemic immunosuppressives (eg, AZA, MTX, MMF, etc)

GHP Family Pharmacy Customer Service
100 N. Academy Ave.
Danville, PA 17822
Tel. • 855•552•6028 PA Relay 711 GeisingerHealthPlan.com

Geisinger

RENEWAL requests

Check all of the following that apply to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.

☐ Experienced an improvement in disease severity or level of functioning since starting therapy with the requested medication

☐ Is prescribed an increased dose or more frequent administration of the requested medication

- ☐ New dose/frequency is within the FDA-approved recommended dosing OR is supported by national compendia or peer-reviewed medical literature

☐ **Requested drug is OTEZLA (apremilast)** or **SILIQ (brodalumab):**

- ☐ Was recently reevaluated for behavioral and mood changes

Please submit to PromptPA https://ghp.promptpa.com OR fax to Geisinger Health Plan at 570-271-5610 the completed form with required clinical documentation.

Prescriber Signature:	**Date**: