Preauthorization Request Form

(Autoimmune therapies only)

Please complete each section of this form. Incomplete forms may be returned to sender for additional information. NOTE: For your patient to receive the lowest out-of-pocket costs, use in-network providers unless preauthorization is obtained. Decisions are based on eligibility, benefit determination and medical necessity.

Member name: _____ Date of Birth: _____

Member ID Number: _____ Group Number: _____

Requested start date: _____

Drug (pharmacy benefit preferred drugs listed)

- ☐ Actemra (tocilizumab)
- ☐ Cosentyx (secukinumab)
- ☐ Enbrel (etanercept)
- ☐ Humira (adalimumab)
- ☐ Otezla (apremilast)
- ☐ Rinvoq (upadacitinib)
- ☐ Skyrizi (risankizumab-rzza)
- ☐ Stelara (ustekinumab)
- ☐ Tremfya (guselkumab)
- ☐ Xeljanz/Xeljanz XR (tofacitinib)
- ☐ Other: _____

Dose & Schedule Requested: _____

HCPCS code(s), please list all that apply (if applicable): _____

Drug (medical benefit drugs listed)

- ☐ Actemra IV (tocilizumab)
- ☐ Entyvio (vedolizumab)
- ☐ Orencia IV (abatacept)
- ☐ Renflexis (infliximab-abda)
- ☐ Stelara IV (ustekinumab)
- ☐ Simponi Aria (golimumab)
- ☐ Inflectra (infliximab-dyyb)
- ☐ Other: _____

Dose & Schedule Requested: _____

Facility where drug will be administered: _____ Facility NPI: _____

List of medical benefit drugs is not all-inclusive. In some instances, the Health Plans preauthorization policy may dictate use of a preferred drug product (i.e. self-administered drug, biosimilars, etc.) prior to use of other agents. Refer to drug-specific PA policy for a complete list of medical criteria for coverage.

ICD code(s), please list all that apply: _____

- ☐ Ankylosing spondylitis
- ☐ Crohn's disease
- ☐ Ulcerative Colitis
- ☐ Hydradenitis suppurativa
- ☐ Juvenile idiopathic arthritis
- ☐ Psoriatic arthritis
- ☐ Rheumatoid arthritis (moderate to severe)
- ☐ Uveitis
- ☐ Plaque psoriasis (moderate to severe)
  - ☐ BSA <3% ☐ BSA 3-10% ☐ BSA >10%
- ☐ Other: _____

Clinical information

☐ Initial therapy ☐ Continuation of therapy (see below)

For initial therapy, please complete questions below.

1. Prior to initiating therapy, has patient been screened for latent TB infection with either a TB skin test or an interferongamma release assay in the last 12 months? Yes ☐ No ☐
2. Has active TB been ruled out? Yes ☐ No ☐
3. Is the patient at risk for hepatitis B (HBV)? Yes ☐ No ☐
4. Will the medication be used in combination with another biologic agent? Yes ☐ No ☐

5. Is the medication prescribed by, or in consultation with, a specialist? Yes ☐ No ☐

6. Is the member the appropriate age noted in the policy for the indication? Yes ☐ No ☐

7. Has the member had a documented treatment failure, intolerance, or contraindication to pre-requisite ***non-pharmacologic*** therapies (ex. phototherapy) noted in policy for the indication (if applicable)? Yes ☐ No ☐ n/a ☐

   If "No" please provide clinical rationale as to why ***non-pharmacologic*** therapies are not clinically appropriate:

   _____

8. Has the member had a documented treatment failure, intolerance, or contraindication to pre-requisite ***non-biologic*** drug therapies noted in policy for the indication (if applicable)? Yes ☐ No ☐ n/a ☐

   If "No" please provide clinical rationale as to why ***non-biologic*** drug therapies are not clinically appropriate:

   _____

9. Has the member had a documented treatment failure, intolerance, or contraindication to *ALL* preferred ***biologic*** drug therapies noted in the policy for the indication (if applicable)? Yes ☐ No ☐ n/a ☐

   If "No" please provide clinical rationale as to why the non-preferred drug is deemed medically necessary versus preferred therapies:

   _____

For continuation of therapy, has the patient completed an annual clinical evaluation and effectiveness clearly documented? Yes ☐ No ☐

If "No" please provide clinical rationale as to why the requested drug should be deemed medically necessary for continuation:

_____

NOTE: Clinical effectiveness established based on the use of drug samples that bypasses policy requirements is not considered a prerequisite for continued coverage. Additionally, prior coverage of a drug under a previous insurance carrier is not a prerequisite for continued coverage under Avera Health Plans.

Provider Name: _____ Office/Facility Name: _____

Person completing the form: _____ Form Completion Date: _____

Person reviewing the form: _____ Form Review Date: _____

Phone Number: (_____) _____ Fax Number: (_____) _____

Determination of medical necessity requires the submission of clinical documentation.

☐ Clinical documentation is available in the Avera electronic medical record for review.
Please list date(s) of pertinent records: _____

☐ Clinical documentation is not available in the Avera electronic medical record for review. Pertinent clinical records for the previous 12 months are attached for review.

Final determination will be faxed to the prescriber. Final determination will be mailed to the member.

IMPORTANT NOTICE*:* This determination does not guarantee benefits or payment of services. Payment of services is subject to patient eligibility at the time of treatment, benefit plan limitations and the other terms of the benefit plan. Payment of benefits is only made for services deemed medically necessary and appropriate. The final payment decision will be made upon submission of a claim. If you have questions about your benefits, please contact Avera Health Plans Customer Care team at 605-322-4545 or toll-free at 1-888-322-2115. This form is not all-inclusive of services requiring preauthorization. Refer to patient's Certificate of Coverage, Master Contract or Summary Plan Document for more information.

Fax this completed form to Avera Health Plans at **1-800-269-8561** or send a secure email to Pharmacy@AveraHealthPlans.com.