Cytokine & CAM Antagonists

Please fax this completed form to (833) 645-2734 OR mail to: Pharmacy Services| 5 River Park Place East, Suite 210 | Fresno, CA 93720.
You can also complete online at CoverMyMeds.com.

Date of request:	Reference #:	MAS:	
Patient	Date of birth	ProviderOne ID or Coordinated Care ID	
Pharmacy name	Pharmacy NPI	Telephone number	Fax number
Prescriber	Prescriber NPI	Telephone number	Fax number
Medication and strength	Directions for use	Qty/Days supply	

1. Is client currently stable on therapy? ☐ Yes ☐ No
   If yes, is there documentation of positive clinical response? ☐ Yes ☐ No

2. What is patient's current weight? _____ kg Date taken: _____

3. Indicate patient's diagnosis:
   ☐ Ankylosing Spondylitis (AS) ☐ Crohn's Disease (CD) ☐ Hidradenitis Suppurativa (HS)
   ☐ Juvenile Idiopathic Arthritis (JIA) ☐ Plaque Psoriasis (Ps) ☐ Psoriatic Arthritis (PsA)
   ☐ Rheumatoid Arthritis (RA) ☐ Ulcerative Colitis (UC)
   ☐ Non-radiographic axial spondyloarthritis
   ☐ Non-infectious Uveitis (UV) classified as intermediate, posterior or panuveitis
   ☐ Other. Specify: _____

4. Has patient tried and failed, has an intolerance or contraindication to any of the following(check all that apply):
   ☐ Acetretin ☐ Corticosteroids ☐ Enbrel (etanercept)
   ☐ Humira (adalimumab) ☐ mesalamine/budesonide MMX ☐ NSAIDs
   ☐ Phototherapy ☐ systemic antibiotics ☐ topical therapies
   ☐ Non-biologic DMARD(s) (azathioprine, cyclosporine, hydroxychloroquine, leflunomide, 6-mercaptopurine, methotrexate, sulfasalazine)
   ☐ Other. Specify: _____

5. Will patient be taking any of the following in combination with this request (mark all that apply)?
   ☐ Biologic DMARD ☐ Phosphodiesterase (PDE 4) inhibitor
   ☐ Janus kinase inhibitor ☐ None

6. Does patient have a negative TB test within the last year? ☐ Yes ☐ No

7. Is this prescribed by or in consultation with any of the following (mark all that apply):
   ☐ Dermatologist ☐ Gastroenterologist ☐ Ophthalmologist
   ☐ Rheumatologist ☐ Other. Specify: _____

CHART NOTES ARE REQUIRED WITH THIS REQUEST

Prescriber signature	Prescriber specialty	Date

Pharmacy Services will respond via fax or phone within 24 hours of receipt of the request. Requests for prior authorization must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)