Prescription Medication Prior Authorization Request Form

☐ Standard PA Request ☐ Urgent/Expedited PA Request

Please fill out all sections and attach any important documentation such as chart notes or lab results to support the PA request.
Once completed, submit to WithMe Health via fax at **1-866-678-8301**

Patient Information

Patient Name (Last, First, MI):		
Member ID Number:	Date of Birth:	Patient Phone Number:
Patient Address:		
Patient's Authorized Representative (If applicable):		Authorized Rep Phone Number:

Provider Information

Requesting Provider's Name:		
NPI:	Specialty:	
Office Address:		
Office Phone:	Office Fax:	
Office Contact Name:	Phone:	Fax:
Dispensing Pharmacy Name/Place of Service:	Phone:	Fax:

Requested Medication Information

Medication Name and Strength:	
Dose and Frequency (Sig):	
Qty Per 30 Days:	Expected Duration of Therapy:
ICD-10(s):	Diagnosis:

Please check one of the boxes below. If established, please include therapy start date:

☐ New Therapy ☐ Samples ☐ Clinical Trial ☐ Established Date Therapy Started: _____

Previous Therapies Used for Diagnosis (Rx and OTC products)

Medication Name, Strength, Dose, Frequency	Dates Used	Outcome of Therapy (e.g., Ineffective, Not Tolerated)

Medical Rationale for Use of Requested Medication (**Please attach chart notes, lab work etc. when submitting this request. If applicable, please include why formulary therapies may be contraindicated for this patient.** Please also include which therapies will be used along with the requested medication. If patient is established on the requested medication, please include recent documentation of how the patient has responded to therapy.):

Disease State Specific Questions

If the diagnosis is Ankylosing Spondylitis/non-radiographic Axial Spondyloarthritis, please provide the following information:

1. Is the drug being requested Cosentyx (secukinumab), Cimzia (certolizumab), Enbrel (etanercept), Humira (adalimumab,) Simponi (golimumab), or Taltz (ixekizumab)? ☐ Yes ☐ No
2. Was the diagnosis of ankylosing spondylitis or non-radiographic axial spondyloarthritis established by a rheumatologist? ☐ Yes ☐ No
3. Has the patient failed to adequately respond to, was intolerant to, or has a contraindication to a 2 to 4-week trial of at least TWO NSAIDs? ☐ Yes ☐ No

If the diagnosis is Behçet's Disease (BD), please provide the following information:

1. Is the requested drug one of the following: Enbrel (etanercept), Humira (adalimumab) or Otezla (apremilast)? ☐ Yes ☐ No
2. Does patient have diagnosis of BD with oral ulcers as a primary manifestation of their disease? ☐ Yes ☐ No
3. Has the patient had an inadequate response to, has not tolerated or has contraindications to topical glucocorticoids (e.g., triamcinolone)? ☐ Yes ☐ No
4. Has the patient had an inadequate response to, has not tolerated or has contraindications to an adequate course of oral glucocorticoids. ☐ Yes ☐ No
5. Has the patient has had an inadequate response to, not tolerated or has contraindications to an adequate course of at least ONE cDMARDs? ☐ Yes ☐ No

If the diagnosis is Cryopyrin-associated periodic syndrome, please provide the following information:

1. Is the requested drug one of the following: Kineret (Anakira)? ☐ Yes ☐ No
2. Does the patient have a specific diagnosis of the NOMID subtype of CAPS established by a rheumatologist? ☐ Yes ☐ No

If the diagnosis is Chron's disease, please provide the following information:

1. Is the requested drug one of the following: Cimzia (certolizumab), Humira (adalimumab) or Stelara (ustekinumab, SC)? ☐ Yes ☐ No
2. Was the diagnosis of moderate to severe Crohn's disease established by a gastroenterologist? ☐ Yes ☐ No
3. Please indicate which of the following the patient was intolerant to, had contraindications to or failed to adequately respond to a minimum of a three-month trial

   ☐ Aminosalicylates (sulfasalazine, Pentasa, Asacol, or Colazal)

   ☐ Glucocorticoids

   ☐ Immunomodulators (azathioprine, 6-mercaptopurine or methotrexate)

If the diagnosis is cytokine release syndrome, please provide the following information:

1. Is the requested drug one of the following: Actemra (tocilizumab)? ☐ Yes ☐ No
2. Is the diagnosis of cytokine release syndrome due to treatment with CAR-T therapy (either Kymriah [tisagenlecleucel]), Yescarta [axicabtagene], or Tecartus [brexucabtagene autoleucel])? ☐ Yes ☐ No
3. Will the treatment be administered in combination with a high-dose corticosteroid? ☐ Yes ☐ No

If the diagnosis is giant cell arthritis, please provide the following information:

1. Is the requested drug one of the following: Actemra (tocilizumab)? ☐ Yes ☐ No
2. Diagnosis of giant cell arteritis established by a rheumatologist or neurologist? ☐ Yes ☐ No
3. Please indicate how the patient's diagnosis was confirmed:
   - ☐ Temporal artery biopsy
   - ☐ Cross-sectional imaging
   - ☐ Other

4. Indicate if the patient is intolerant to, has a contraindication to or failed to sustain remission on an adequate trial of either of the following
   - ☐ High-dose glucocorticoids (40 to 60 mg per day or equivalent) tapered no faster than over six months
   - ☐ Methotrexate
   - ☐ N/A

If the diagnosis is treatment of Hidradenitis suppurativa, please provide the following information:

1. Is the requested drug one of the following: Humira (adalimumab)? ☐ Yes ☐ No
2. Was the diagnosis established by a dermatologist? ☐ Yes ☐ No
3. Indicate which of the following diagnostic criteria apply:

   ☐ Hurley stage II: recurrent abscesses with sinus tracts and scarring, single or multiple widely separated lesions. The patient has had antibiotic treatment of atleast 12 weeks that was either ineffective, not tolerated or was contraindicated.Antibiotics may include tetracycline, doxycycline, minocycline, erythromycin, ortopical clindamycin

   ☐ Hurley stage III: diffuse or almost diffuse involvement, or multiple interconnected sinus tracts and abscesses across the entire area

If the diagnosis is treatment of juvenile idiopathic arthritis (JIA), please provide the following information:

1. Is the requested drug one of the following: Actemra (tocilizumab, SC) Enbrel (etanercept) Humira (adalimumab) Orencia (abatacept, SC) or Xeljanz (tofacitinib)? ☐ Yes ☐ No
2. Was the diagnosis established by a rheumatologist? ☐ Yes ☐ No
3. Has the patient been found to be intolerant to, have contraindications to or failed to adequately respond to a minimum of a three-month trial with methotrexate? ☐ Yes ☐ No
4. If not, is the patient a candidate for methotrexate therapy? ☐ Yes ☐ No

If the diagnosis is plaque psoriasis, please provide the following information:

1. Is the drug being requested Cimzia (certolizumab), Enbrel (etanercept), Humira (adalimumab), Ilumya (tildrakizumab), Otezla (apremilast), Cosentyx (secukinumab), Siliq (brodalumab), Stelara (ustekinumab), Taltz (ixekizumab), Tremfya (guselkumab), or Skyrizi (risankizumab-rzaa)? ☐ Yes ☐ No
2. Does the patient have a diagnosis of moderate to severe plaque psoriasis, affecting 10% or more of total Body Surface Area (BSA), as established by a rheumatologist or dermatologist? ☐ Yes ☐ No
3. Please indicate which of the following apply to patient:
   - ☐ treatment with phototherapy or photochemotherapy was ineffective, not tolerated or is contraindicated
   - ☐ treatment with an adequate treatment course of at least three months with a cDMARD and/or a retinoid (e.g., Soriatane) was ineffective, not tolerated, or all cDMARDs are contraindicated
   - ☐ dosing will not exceed FDA approved dosing for appropriate age ranges
   - ☐ Patient has not tried phototherapy or photochemotherapy
   - ☐ Patient has not tried a cDMARD and/or a retinoid

If the diagnosis is Psoriatic Arthritis, please provide the following information:

1. Is the drug being requested Cimzia (certolizumab), Cosentyx (secukinumab,) Enbrel (etanercept), Humira (adalimumab), Orencia (abatacept) Otezla (apremilast), Simponi (golimumab), Stelara (ustekinumab), Taltz (ixekizumab), Tremfya (guselkumab) or Xeljanz, Xeljanz XR (tofacitinib)? ☐ Yes ☐ No
2. Was the diagnosis of psoriatic arthritis established by a rheumatologist or dermatologist? ☐ Yes ☐ No
3. Has the patient has had an inadequate response to, was intolerant or has contraindications to optimal doses of methotrexate or sulfasalazine for at leastthree months or cDMARDs are clinically inappropriate? ☐ Yes ☐ No

If the diagnosis is Rheumatoid Arthritis (RA), please provide the following information:

1. Is the drug being requested Actemra (tocilizumab), Cimzia (certolizumab), Enbrel (etanercept), Humira (adalimumab), Kevzara (sarilumab), Kineret (anakinra), Olumiant (baricitinib), Orencia SC (abatacept), Rinvoq (upadacitinib), Simponi (golimumab), Xeljanz, Xeljanz XR (tofacitinib)? ☐ Yes ☐ No
2. Was the diagnosis of moderate to severe active rheumatoid arthritis established by a rheumatologist, based on the American College of Rheumatology (ACR)/European League Against Rheumatism (EULAR) criteria for the diagnosis of rheumatoid arthritis? ☐ Yes ☐ No
3. Has the patient had an initial assessment of their current status using the RAPID3? ☐ Yes ☐ No
4. Is there is documentation that the patient was intolerant to, had contraindications to or treatment was ineffective after a minimum of a three-month course with at least one cDMARD? ☐ Yes ☐ No
5. Will the treatment be administered in combination with a cDMARD, unless all cDMARDs are not tolerated or are contraindicated? ☐ Yes ☐ No

If the diagnosis Systemic Juvenile Idiopathic Arthritis or Adult-Onset Still's Disease, please provide the following information:

1. Is the drug being requested Actemra (tocilizumab, SC) Kineret (anakinra) Orencia (abatacept, SC)? ☐ Yes ☐ No
2. Was the diagnosis of systemic juvenile idiopathic arthritis or adult-onset Still's disease established by a rheumatologist? ☐ Yes ☐ No
3. There is documentation that the patient was intolerant to, had contraindications to or failed to adequately respond to a minimum of a three-month trial with methotrexate? ☐ Yes ☐ No
4. Is methotrexate clinically inappropriate? ☐ Yes ☐ No

If the diagnosis ulcerative colitis, please provide the following information:

1. Is the drug being requested Humira (adalimumab) Simponi (golimumab) Xeljanz, Xeljanz XR (tofacitinib)? ☐ Yes ☐ No
2. Was the diagnosis of moderate to severe active ulcerative colitis established by a gastroenterologist? ☐ Yes ☐ No
3. Indicate which of the following the patient has had an inadequate response with:
   - ☐ Aminosalicylates or 5-ASAs (e.g., sulfasalazine, Pentasa, Asacol or Colazal)
   - ☐ Glucocorticoids (e.g., prednisone, oral or rectal budesonide)
   - ☐ Immunomodulators (e.g., azathioprine, 6-mercaptopurine, or methotrexate)
   - ☐ Patient has not tried/had an inadequate response with any of the above

If the diagnosis uveitis, please provide the following information:

1. Is the drug being requested Humira (adalimumab)? ☐ Yes ☐ No
2. Was the diagnosis of non-infectious uveitis (either intermediate, posterior, or panuveitis) established by a rheumatologist or ophthalmologist.? ☐ Yes ☐ No
3. Please indicate which of the following apply:
   - ☐ The patient has had an inadequate response to (see Appendix 4), does not tolerate or has contraindications to treatment with a cDMARD
   - ☐ The patient has had an inadequate response to (see Appendix 4), has been unable to taper, does not tolerate or has contraindications to treatment a three-month course of therapy with oral glucocorticoids
   - ☐ The patient has not tried a cMARD or an oral glucocorticoid

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that documentation supporting this information is available for review if requested by WithMe Health, the health plan sponsor, or, if applicable, a state or federal regulatory agency.

_____ _____

Provider Signature Date