



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:

<input type="checkbox"/> Ankylosing Spondylitis (AS)	<input type="checkbox"/> Crohn's Disease (CD)	<input type="checkbox"/> Hidradenitis Suppurativa (HS)
<input type="checkbox"/> Juvenile Idiopathic Arthritis (JIA)	<input type="checkbox"/> Plaque Psoriasis (Ps)	<input type="checkbox"/> Psoriatic Arthritis (PsA)
<input type="checkbox"/> Rheumatoid Arthritis (RA)	<input type="checkbox"/> Ulcerative Colitis (UC)	
<input type="checkbox"/> Non-radiographic axial spondyloarthritis		
<input type="checkbox"/> Non-infectious Uveitis (UV) classified as intermediate, posterior or panuveitis		
<input type="checkbox"/> Other. Specify: _____		

4. Has patient tried and failed, has an intolerance or contraindication to any of the following (check all that apply):

<input type="checkbox"/> Acetretin	<input type="checkbox"/> Corticosteroids	<input type="checkbox"/> Enbrel (etanercept)
<input type="checkbox"/> Humira (adalimumab)	<input type="checkbox"/> mesalamine/budesonide MMX	<input type="checkbox"/> NSAIDs
<input type="checkbox"/> Phototherapy	<input type="checkbox"/> systemic antibiotics	<input type="checkbox"/> topical therapies
<input type="checkbox"/> Non-biologic DMARD(s) (azathioprine, cyclosporine, hydroxychloroquine, leflunomide, 6-mercaptopurine, methotrexate, sulfasalazine)		
<input type="checkbox"/> Other. Specify: _____		

5. Will patient be taking any of the following in combination with this request (mark all that apply)?

<input type="checkbox"/> Biologic DMARD	<input type="checkbox"/> Phosphodiesterase (PDE 4) inhibitor
<input type="checkbox"/> Janus kinase inhibitor	<input type="checkbox"/> None

6. Does patient have a negative TB test? Yes No

7. Is this prescribed by or in consultation with any of the following (mark all that apply):

<input type="checkbox"/> Dermatologist	<input type="checkbox"/> Gastroenterologist	<input type="checkbox"/> Ophthalmologist
<input type="checkbox"/> Rheumatologist	<input type="checkbox"/> Other. Specify: _____	

CHART NOTES ARE REQUIRED WITH THIS REQUEST

Prescriber signature	Prescriber specialty	Date
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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.)