Request for Prior Authorization: Biologicals for Hidradenitis Suppurativa

Iowa | Iowa Health Link • Hawki

Contains confidential patient information

Instructions

Complete this form in its entirety and fax to Prior Authorization of Benefits Center at **844-512-9004**.
If you have any questions, use the Chat with Payer feature in https://Availity.com or contact Provider Services at **833-731-2143**, Monday through Friday, 7:30 a.m. to 6 p.m. CT.

1. Patient information | 2. Provider and pharmacy information

1. Patient information	2. Provider and pharmacy information
IA Medicaid member ID:	Prescriber NPI:
Patient name:	Prescriber name:
DOB:	Prescriber phone:
Patient address:	Prescriber address:
	Prescriber fax:
	Pharmacy name:
	Pharmacy address:
	Pharmacy phone:
Prescriber must complete all information above. It must be legible, correct, and complete or the form will be returned.	
Pharmacy NPI:	Pharmacy fax:
NDC:	

Select all boxes that apply. Note: Any areas not filled out will be considered not applicable to your patient and may affect the outcome of this request.

3. Approval criteria

Prior authorization (PA) is required for biologicals FDA approved or compendia indicated for the treatment of hidradenitis suppurativa (HS). Payment for nonpreferred biologic agents will be considered only for cases in which there is documentation of a previous trial and therapy failure with a preferred biologic agent.

Payment will be considered under the following conditions:

1. Request adheres to all FDA-approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in special populations; and
2. Patient has a diagnosis of moderate to severe HS with hurley stage ll or lll disease; and
3. Patient has documentation of an adequate trial and therapy failure with at least one oral antibiotic/oral antibiotic combination (e.g., doxycycline, clindamycin, rifampin).

If criteria for coverage are met, initial requests will be given for four months. Additional authorizations will be considered upon documentation of positive response to therapy.

The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

4. Drug selection

Preferred

☐ Adalimumab-aacf
☐ Adalimumab-adbm
☐ Adalimumab-fkjp
☐ Humira
☐ Simlandi
☐ Yusimry

Nonpreferred

☐ Bimzelx
☐ Cosentyx
☐ Other Humira Biosimilar; specify below
Drug name: ________________________

Strength	Dosage instructions	Quantity	Days supply

5. Diagnosis

☐ Hidradenitis suppurativa: Hurley stage ☐ I ☐ II ☐ III

☐ Other: ____

Document oral antibiotic/oral antibiotic combination trial

Trial			
Name and dose		Trial dates	
Failure reason			

6. Renewals

Document positive response to therapy:

Possible drug interactions/conflicting drug therapies:

Attach lab results and other documentation as necessary.

7. Physician signature

Prescriber or authorized signature
Must match prescriber named above.

Date submitted

Prior authorization of benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

Important note: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Health and Human Services, that the member continues to be eligible for Medicaid.

Important note: You are not permitted to use or disclose Protected Health Information about individuals who you are not treating or are not enrolled to your practice. This applies to Protected Health Information accessible in any online tool, sent in any medium including mail, email, fax or other electronic transmission.