This form must be completed by the prescriber or authorized personnel. INCOMPLETE FORMS WILL BE RETURNED.

### Member Information

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### Prescriber Information

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### Requested Medication

Medication: _________________________________________

Dose / Frequency: ______________________________________________________________________________________________________

*Please attach progress notes for the patient’s most recent 2-3 office visits. If this documentation is not attached the request cannot be approved.

### Clinical Criteria Documentation

1. What is the primary diagnosis? ______________________________________ ICD Code: ______________________

2. Indicate the request type  □ New Start  □ Renewal. Date therapy was started: ______________________

Note: patient use of free goods or samples does not qualify as an established patient or guarantee coverage.

All policy criteria must be met in order to obtain coverage.

3. Has the patient been screened to rule out the presence of latent TB infection prior to initiating treatment?
   □ Yes  □ No

4. Has the patient been evaluated and screened for the presence of hepatitis B virus?
   (Only needed for: Actemra®, Enbrel®, Cimzia®, Humira®, Orencia®, Simponi®).
   □ Yes  □ No

5. Does the patient have any active infections, including clinically important localized infections?
   □ Yes  □ No

6. Will the patient receive any live vaccines while on therapy?
   □ Yes  □ No

7. Will the patient be taking this with a TNF inhibitor or Biological DMARD (e.g., Orencia®, Kineret®, Xeljanz®, Actemra®, etc.)?
   If YES, please list agent(s): ________________________________________________________________
   □ Yes  □ No

8. Is the patient unable to tolerate methotrexate?
   If YES, please explain: ______________________________________________________________________
   □ Yes  □ No

9. List ALL medications/treatments the patient has tried and failed that relate to this request (include the dates and outcomes):

   Medication: ______________________ Dates Used: ______________________ Outcome: ______________________

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   Medication: ______________________ Dates Used: ______________________ Outcome: ______________________
10. Does the patient have a history of seizure disorders or multiple sclerosis?  
   □ Yes  □ No

11. Is the patient currently pregnant or breast-feeding?  
   □ Yes  □ No

For Diagnosis of Crohn’s Disease (In addition to above questions)
   a. Indicate the severity of the patient’s Crohn’s disease.  □ Mild  □ Moderate  □ Severe
   b. What is the patient’s Crohn’s Disease Activity Index (CDAI)? Please provide documentation ________________

For Diagnosis of Ankylosing Spondylitis (In addition to above questions)
   a. What is the patient’s Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) score? ________________
   b. What is the patient’s Visual Analog Score (VAS) for total back pain? ________________

For Diagnosis of Plaque Psoriasis (PsO) (In addition to above questions)
   a. Indicate the severity of the patient’s Plaque Psoriasis  □ Mild  □ Moderate  □ Severe
   b. Does the patient have plaques covering ≥ 10% of their BSA or involvement of palms, soles, head and neck, or genitalia that causes disruption to normal activities?  □ Yes  □ No
   c. Will the patient be concurrently prescribed phototherapy?  □ Yes  □ No
      If NO, has the patient tried and failed phototherapy (e.g., psoralens with UVA light or UVB with coal tar)?
      Please explain: _______________________________________________________________________________

   d. What is the patient’s Psoriasis Area and Severity Index (PASI) score? __________________

For Diagnosis of Psoriatic Arthritis (In addition to above questions)
   a. Indicate the severity of the patient’s Psoriatic Arthritis  □ Mild  □ Moderate  □ Severe
   b. Does the patient have any of the following:  □ Enthesitis  □ Dactylitis  □ Axial disease
   c. Please provide documentation of functional disease status. Disease activity measurements must be performed at initiation of therapy and for subsequent renewals. (e.g., RAPID 3, PsARC)
   d. Does the patient have history of plaque psoriasis or peripheral arthritis?  □ Yes  □ No
      If YES, please explain: __________________________________________________________________________

For Diagnosis of Rheumatoid Arthritis (In addition to above questions)
   a. Indicate the severity of the patient’s rheumatoid arthritis.  □ Mild  □ Moderate  □ Severe
   b. Has the patient’s baseline disease severity been assessed?  □ Yes  □ No
      Please provide at least one of the following (chart notes and measuring tool are required to be submitted)
      Clinical Disease Activity Index score (CDAI): ________________
      Disease Activity Score (DAS): ________________
      Patient Activity Scale (PAS): ________________
      Simplified Disease Activity Index score (SDAI): ________________
      Routine Assessment of Patient Index Data 3 (RAPID 3): ________________
      Patient Activity Scale-II (PAS II): ________________
For Diagnosis of Severe Hidradenitis Suppurativa (In addition to above questions)

a. Does the patient have Hurley Stage II or III? □ Yes □ No

b. How many abscesses/inflammatory nodules are present? _______________________________________

For Diagnosis of Ulcerative Colitis (In addition to above questions)

a. Please provide the following Mayo Score: __________________ Endoscopy sub-score: __________________

b. Check all signs/symptoms of moderate to severe disease that apply to patient.
   - Anemia
   - Bowel movements 4 or more times per day
   - Fever
   - Nocturnal stools
   - Persistent abdominal pain
   - Tachycardia
   - Visible blood in stool
   - Other: explain _________________________________________________________

For Diagnosis of Uveitis (In addition to above questions)

a. Does the patient have non-infectious uveitis? □ Yes □ No

b. Does the patient have intermediate, posterior, or panuveitis? □ Yes □ No

Renewal Requests

NOTE: Use of free goods or samples does not qualify as established therapy for renewal.

a. Is ongoing monitoring being performed to rule out TB infection? □ Yes □ No

b. Is the patient experiencing any toxicity from the medication? □ Yes □ No

c. Has the patient had a disease response with the medication? Please provide details on disease response. □ Yes □ No

____________________________________________________________________________________________
____________________________________________________________________________________________

Note: If approved, compliance with therapy is required. Authorizations will be terminated for patients who are noncompliant with therapy.

Prescriber Signature (Required) ________________________________ Date ____________
(By signature, the Physician confirms the above information is accurate and verifiable by patient records.)

Fax This Form to: 866-272-4093.

Mail Requests to:
Magellan Rx Management Prior Authorization Program; c/o Magellan Health, Inc.
4801 E. Washington Street
Phoenix, AZ 85034