Highmark Wholecare
Pharmacy Division
Phone 800-392-1147 Fax 888-245-2049

I. Requirements for Prior Authorization of Cytokine and CAM Antagonists

A. Prescriptions That Require Prior Authorization

All prescriptions for Cytokine and CAM Antagonists must be prior authorized.

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a Cytokine and CAM Antagonist, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. Is prescribed the Cytokine and CAM Antagonist for the treatment of a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling or a medically accepted indication; **AND**

2. Is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**

3. Is prescribed a dose and duration of therapy that are consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**

4. Is prescribed the Cytokine and CAM Antagonist by or in consultation with an appropriate specialist (e.g., gastroenterologist, dermatologist, rheumatologist, ophthalmologist, immunologist, genetic specialist, pulmonologist, oncologist, etc.); **AND**

5. Does not have a contraindication to the prescribed drug; **AND**

6. If currently using a different Cytokine and CAM Antagonist, **one** of the following:

   a. Will discontinue use of that Cytokine and CAM Antagonist prior to starting the requested Cytokine and CAM Antagonist

   b. **One** of the following:
      i. Has a medical reason for concomitant use of both Cytokine and CAM Antagonists that is supported by peer-reviewed medical literature or national treatment guidelines,
      ii. Is dependent on glucocorticoids in addition to a Cytokine and CAM Antagonist to prevent life-threatening complications,
      iii. Has two or more autoimmune or autoinflammatory conditions for which a single Cytokine and CAM Antagonist is not sufficient;

   AND

7. For a Cytokine and CAM Antagonist associated with an increased risk of infection according to the FDA-approved package labeling, was evaluated for **both** of the following if recommended in the FDA-approved package labeling:

   a. Active or latent tuberculosis infection documented by results of a tuberculin skin test (purified protein derivative) or blood test (interferon-gamma release assay)
   b. Hepatitis B virus infection documented by results of anti-HBs, HBsAg, and anti-HBc;

AND

8. For a Cytokine and CAM Antagonist associated with behavioral and/or mood changes as stated in the FDA-approved package labeling (e.g., Otezla, Siliq), was evaluated for a history of prior suicide attempt, bipolar disorder, or major depressive disorder; **AND**

9. For treatment of Crohn's disease, **one** of the following:

    a. Has a diagnosis of moderate to severe Crohn's disease and **one** of the following:

        i. Failed to achieve remission with or has a contraindication or an intolerance to an induction course of corticosteroids

        ii. **One** of the following:
            a) Failed to maintain remission with a conventional immunomodulator in accordance with current consensus guidelines[1]
            b) Has a contraindication or an intolerance to conventional immunomodulators in accordance with current consensus guidelines,

    b. Has a diagnosis of Crohn's disease that is associated with one or more high-risk or poor prognostic feature(s),[2]

    c. **Both** of the following:

        i. Has achieved remission with the requested Cytokine and CAM Antagonist
        ii. Will be using the requested drug as maintenance therapy to maintain remission;

AND

10. For treatment of ulcerative colitis (UC), **one** of the following:

    a. **Both** of the following:

        i. Has **one** of the following diagnoses:
            a) Mild UC that is associated with multiple poor prognostic factors[3]
            b) Moderate to severe UC

        ii. **One** of the following:

            a) Failed to achieve remission with or has a contraindication or an intolerance to an induction course of corticosteroids

[1] e.g., American College of Gastroenterology [ACG], American Gastroenterological Association [AGA], Canadian Association of Gastroenterology [CAG], European Crohn's and Colitis Organization [ECCO]

[2] Examples of high-risk or poor prognostic features in patients with Crohn's disease include initial diagnosis or clinical evidence supports the onset of symptoms at <30 years of age, extensive anatomic involvement, presence of fistula, perianal and/or severe rectal disease, large or deep mucosal lesions on endoscopy or imaging, prior surgical resection, stricturing and/or penetrating behavior, need for steroid therapy at initial diagnosis, extra-intestinal manifestations, laboratory markers such as low hemoglobin, low albumin, high C-reactive protein, high fecal calprotectin levels, severe growth delay (AGA 2014; ECCO 2017; CAG 2019; ECCO-ESPGHAN 2021; AGA 2021).

[3] Examples of poor prognostic factors in patients with ulcerative colitis include initial diagnosis or clinical evidence supports the onset of symptoms at <40 years of age, extensive colitis, severe endoscopic disease (presence of large and/or deep ulcers), hospitalization for colitis, elevated inflammatory markers, low serum albumin, extra-intestinal manifestations, early need for corticosteroids (ACG 2019; AGA 2019; AGA 2020).

b) **One** of the following:
(i) Failed to maintain remission with a conventional immunomodulator in accordance with current consensus guidelines[4]
(ii) Has a contraindication or an intolerance to conventional immunomodulators in accordance with current consensus guidelines

b. **Both** of the following:

i. Has achieved remission with the requested Cytokine and CAM Antagonist
ii. Will be using the requested drug as maintenance therapy to maintain remission;
AND

11. For treatment of moderately to severely active rheumatoid arthritis, has **one** of the following:

a. A history of therapeutic failure of a three-month trial of a conventional non-biologic disease-modifying antirheumatic drug (DMARD) in accordance with current consensus guidelines[5]
b. A contraindication or an intolerance to conventional non-biologic DMARDs;
AND

12. For treatment of juvenile idiopathic arthritis (JIA), **one** of the following:

a. Has **one** of the following:

i. A history of therapeutic failure of a three-month trial of a conventional non-biologic DMARD
ii. A contraindication or an intolerance to non-biologic DMARDs,

b. Has systemic JIA with active systemic features,[6]

c. Has a diagnosis of JIA that is associated with **both** of the following:

i. One or more risk factors[7] for disease severity

ii. At least **one** of the following:
a) Involvement of high-risk joints (e.g., cervical spine, hip, wrist),
b) High disease activity,
c) High risk of disabling joint damage as judged by the prescriber,

d. Has active sacroiliitis and/or enthesitis and **one** of the following:

i. A history of therapeutic failure of a two-week trial of an oral non-steroidal anti-inflammatory drug (NSAID)
ii. A contraindication or an intolerance to oral NSAIDs;

[4] e.g., American College of Gastroenterology [ACG], American Gastroenterological Association [AGA], Canadian Association of Gastroenterology [CAG], European Crohn's and Colitis Organization [ECCO]
[5] e.g., American College of Rheumatology [ACR], European League Against Rheumatism [EULAR]
[6] Active systemic features in patients with JIA include the following: fever, evanescent rash, lymphadenopathy, hepatomegaly, splenomegaly, and serositis (ACR 2013).
[7] Risk factors for disease severity in patients with JIA include positive anti-cyclic citrullinated peptide antibodies, positive rheumatoid factor, presence of joint damage (ACR-AF 2019).

AND

13. For treatment of adult-onset Still's disease, **one** of the following:

    a. Has predominantly systemic disease and **one** of the following:

        i. Has a history of therapeutic failure of or a contraindication or an intolerance to systemic glucocorticoids

        ii. **Both** of the following:
            a) Has glucocorticoid-dependent Still's disease
            b) Will be using the requested Cytokine and CAM Antagonist with the intent of discontinuing or decreasing the dose of the systemic glucocorticoid

    b. Has predominantly joint disease and **one** of the following:

        i. A history of therapeutic failure of a conventional non-biologic DMARD
        ii. A contraindication or an intolerance to conventional non-biologic DMARDs;

    AND

14. For treatment of ankylosing spondylitis or other axial spondyloarthritis, has **one** of the following:

    a. A history of therapeutic failure of a two-week trial of continuous treatment with two different oral NSAIDs (i.e., an oral NSAID taken daily for two weeks and a different oral NSAID taken daily for two weeks)
    b. A contraindication or an intolerance to oral NSAIDs;

    AND

15. For treatment of active[8] psoriatic arthritis (PsA), **one** of the following:

    a. Has **one** of the following:
        i. A history of therapeutic failure of an eight-week trial of a conventional non-biologic DMARD
        ii. A contraindication or an intolerance to conventional non-biologic DMARDs,

    b. Has axial disease, dactylitis, and/or enthesitis,

    c. Has severe disease as determined by the prescriber,[9]

    d. Has concomitant moderate to severe nail disease,

    e. Has concomitant active inflammatory bowel disease;

    AND

[8] Active PsA is defined as disease causing symptoms at an unacceptable bothersome level as reported by the patient and judged by the examining clinician to be due to PsA based on 1 or more of the following: swollen joints, tender joints, dactylitis, enthesitis, axial disease, active skin and/or nail involvement, and extraarticular inflammatory manifestations such as uveitis or IBD (ACR-NPF 2018; EULAR 2015).

[9] Examples of severe PsA include the presence of ≥1 of the following: a poor prognostic factor (erosive disease, dactylitis, elevated levels of inflammation markers such as C-reactive protein or erythrocyte sedimentation rate attributable to PsA), long-term damage that interferes with function (e.g., joint deformities, vision loss), highly active disease that causes major impairment in quality of life (i.e., active psoriatic inflammatory disease at many sites [including dactylitis, enthesitis] or function-limiting inflammatory disease at a few sites), and rapidly progressive disease (ACR-NPF 2018; EULAR 2015).

16. For treatment of chronic psoriasis, **both** of the following:

    a. Has psoriasis associated with at least **one** of the following:

        i. A body surface area (BSA) of 3% or more that is affected,
        ii. A BSA of less than 3% that is affected with involvement of critical areas,[10]
        iii. Significant disability or impairment of physical, mental, or psychosocial functioning

    b. Has **one** of the following:

        i. Moderate to severe nail disease

        ii. **One** of the following:
            a) A history of therapeutic failure of a four-week trial of topical corticosteroids OR an 8-week trial of other topical pharmacologic therapy[11]
            b) A contraindication or an intolerance to topical corticosteroids AND other topical pharmacologic therapy;

    AND

17. For treatment of moderate to severe hidradenitis suppurativa (HS), **one** of the following:

    a. For Hurley stage II disease, has a history of therapeutic failure of or a contraindication or an intolerance to **both** of the following:

        a) A three-month trial of topical clindamycin
        b) An adequate trial of a systemic antibiotic[12]

    b. For Hurley stage III disease, **one** of the following:

        i. Has a history of therapeutic failure of or a contraindication or an intolerance to an adequate trial of a systemic antibiotic
        ii. Is a candidate for or has a history of surgical intervention for HS;

    AND

18. For treatment of non-infectious uveitis, **one** of the following:

    a. Has a diagnosis of uveitis associated with JIA or Behçet's syndrome,

    b. Has a history of therapeutic failure of or a contraindication or an intolerance to **one** of the following:

        i. A systemic, topical, intraocular, or periocular corticosteroid
        ii. A conventional systemic immunosuppressive,[13]

[10] Critical areas in patients with psoriasis include, but are not restricted to, hands, feet, scalp, face, genitals, nails, and intertriginous areas (AAD-NPF 2018).
[11] e.g., anthralin, calcineurin inhibitors, tar, tazarotene, vitamin D analogs
[12] e.g., doxycycline, minocycline, or tetracycline; clindamycin; clindamycin + rifampin; rifampin + moxifloxacin + metronidazole; rifampin + levofloxacin + metronidazole; amoxicillin/clavulanate
[13] e.g., azathioprine, cyclophosphamide, cyclosporine, methotrexate, mycophenolate, tacrolimus

c. **Both** of the following:

i. Has corticosteroid-dependent uveitis[14]
ii. Will be using the requested Cytokine and CAM Antagonist with the intent of discontinuing or decreasing the dose of the systemic corticosteroid;

AND

19. For treatment of giant cell arteritis, **one** of the following:

a. Has a history of therapeutic failure of or a contraindication or an intolerance to systemic glucocorticoids,

b. Is at high-risk for glucocorticoid-related complications,

c. **Both** of the following:
i. Has glucocorticoid-dependent disease
ii. Will be using the requested Cytokine and CAM Antagonist with the intent of discontinuing or decreasing the dose of the systemic glucocorticoid;

AND

20. For treatment of polymyalgia rheumatica, **one** of the following:

a. Has a history of therapeutic failure of or a contraindication or an intolerance to systemic glucocorticoids

b. **Both** of the following:
i. Has glucocorticoid-dependent disease
ii. Will be using the requested Cytokine and CAM Antagonist with the intent of discontinuing or decreasing the dose of the systemic glucocorticoid;

AND

21. For treatment of familial Mediterranean fever, has **one** of the following:

a. A history of therapeutic failure of at least a three-month trial of colchicine at maximum tolerated doses
b. A contraindication or an intolerance to colchicine;

AND

22. For treatment of Behçet's syndrome, **all** of the following:

a. Has a diagnosis of Behçet's syndrome according to current consensus guidelines,[15]

b. Has recurrent oral ulcers associated with Behçet's syndrome,

c. Has a history of therapeutic failure of or a contraindication or an intolerance to a topical corticosteroid (e.g., triamcinolone dental paste),

[14] Corticosteroid-dependent uveitis is defined as requiring a daily systemic corticosteroid dose equivalent to 7.5 mg or greater of prednisone in adults for six weeks or longer.
[15] e.g., EULAR, International Study Group for Behçet's Disease

d. Has **one** of the following:

i. A history of therapeutic failure of an adequate trial of colchicine at maximum tolerated doses
ii. A contraindication or an intolerance to colchicine;

AND

23. For treatment of sarcoidosis, **both** of the following:

a. **One** of the following:

i. Has a history of therapeutic failure of or a contraindication or an intolerance to systemic glucocorticoids
ii. Has glucocorticoid-dependent sarcoidosis

b. **One** of the following:

i. Has a history of therapeutic failure of a conventional non-biologic DMARD
ii. Has a contraindication or an intolerance to conventional non-biologic DMARDs;

AND

24. For treatment of alopecia areata, **both** of the following:

a. Has alopecia associated with at least **one** of the following:

i. Alopecia universalis,
ii. Alopecia totalis,
iii. Greater than 50% scalp involvement,
iv. Significant disability or impairment of physical, mental, or psychosocial functioning

b. Has a current episode of alopecia areata of greater than six months' duration;

AND

25. For spesolimab for treatment of generalized pustular psoriasis (GPP), **one** of the following:

a. For intravenous spesolimab, **both** of the following:

i. Is using intravenous spesolimab for the treatment of a GPP flare

ii. **One** of the following:
a) For a beneficiary who has received a single dose of spesolimab for the current GPP flare, continues to experience moderate to severe GPP flare symptoms since the previous dose of spesolimab
b) For a beneficiary who has not received a dose of spesolimab for the current GPP flare, is experiencing a moderate to severe GPP flare that warrants rapid stabilization or improvement in the opinion of the prescriber

b. For subcutaneous spesolimab, **both** of the following:

i. Has a history of at least one GPP flare
ii. Is using subcutaneous spesolimab for the prevention of GPP flares;

AND

26. For treatment of gout flares, **all** of the following:

    a. Has a history of therapeutic failure of maximum tolerated doses of or a contraindication or an intolerance to NSAIDs,

    b. Has a history of therapeutic failure of maximum tolerated doses of or a contraindication or an intolerance to colchicine,

    c. **One** of the following:
        i. Has a history of therapeutic failure of maximum tolerated doses of or a contraindication or an intolerance to corticosteroids
        ii. Has a medical reason why repeated courses of corticosteroids are not appropriate;

    AND

27. For all other diagnoses, has a history of therapeutic failure of or a contraindication or an intolerance to first line therapy(ies) if applicable according to consensus treatment guidelines; **AND**

28. For an oral Janus kinase (JAK) inhibitor, **one** of the following:

    a. Has a history of therapeutic failure of at least one tumor necrosis factor (TNF) blocker or another biologic if recommended for the beneficiary's diagnosis in the FDA-approved package labeling for the requested oral JAK inhibitor,
    b. Has a contraindication or an intolerance to TNF blockers or other biologics if recommended for the beneficiary's diagnosis in the FDA-approved package labeling for the requested oral JAK inhibitor,
    c. Has a current history (within the past 90 days) of being prescribed an oral JAK inhibitor;

    AND

29. For a non-preferred Cytokine and CAM Antagonist, **one** of the following:

    a. **Both** of the following:

        i. Has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Cytokine and CAM Antagonists approved or medically accepted for the beneficiary's diagnosis
        ii. For a non-preferred Cytokine and CAM Antagonist with a therapeutically equivalent brand or generic, interchangeable biosimilar, or brand or unbranded biologic that is preferred on the Preferred Drug List (PDL), has a history of therapeutic failure of or a contraindication or an intolerance to the preferred therapeutically equivalent brand or generic, interchangeable biosimilar, or brand or unbranded biologic that would not be expected to occur with the requested drug

    b. Has a current history (within the past 90 days) of being prescribed the same non-preferred Cytokine and CAM Antagonist (does not apply to non-preferred brands

when the therapeutically equivalent generic, interchangeable biosimilar, or unbranded biologic is preferred or to non-preferred generics, interchangeable biosimilars, or unbranded biologics when the therapeutically equivalent brand, interchangeable brand, or brand biologic is preferred).

See the PDL for the list of preferred Cytokine and CAM Antagonists at: https://papdl.com/preferred-drug-list;

NOTE: If the beneficiary does not meet the clinical review guidelines above but, in the professional judgement of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

FOR RENEWALS OF PRIOR AUTHORIZATION FOR CYTOKINE AND CAM ANTAGONISTS: The determination of medical necessity of a request for renewal of a prior authorization for a Cytokine and CAM Antagonist that was previously approved will take into account whether the beneficiary:

1. **One** of the following:
   a. Experienced improvement in disease activity and/or level of functioning since initiating therapy with the requested Cytokine and CAM Antagonist
   b. Is prescribed an increased dose or more frequent administration of the requested Cytokine and CAM Antagonist that is supported by peer-reviewed medical literature or national treatment guidelines;
   AND

2. Is prescribed a dose and duration of therapy that are consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**

3. Is prescribed the Cytokine and CAM Antagonist by or in consultation with an appropriate specialist (e.g., gastroenterologist, dermatologist, rheumatologist, ophthalmologist, immunologist, genetic specialist, pulmonologist, oncologist, etc.); **AND**

4. For a Cytokine and CAM Antagonist associated with behavioral and/or mood changes as stated in the FDA-approved package labeling, was recently reevaluated for behavioral and mood changes as recommended in the FDA-approved package labeling; **AND**

5. For a non-preferred Cytokine and CAM Antagonist with a therapeutically equivalent brand or generic, interchangeable biosimilar, or brand or unbranded biologic that is preferred on the PDL, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred therapeutically equivalent brand or generic, interchangeable biosimilar, or brand or unbranded biologic that would not be expected to occur with the requested drug.

   See the PDL for the list of preferred Cytokine and CAM Antagonists at: https://papdl.com/preferred-drug-list;

   NOTE: If the beneficiary does not meet the clinical review guidelines above but, in the

professional judgement of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

C. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for a Cytokine and CAM Antagonist. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary.

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CYTOKINE AND CAM ANTAGONISTS PRIOR AUTHORIZATION FORM *(form effective 1/6/2025)*

☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

STARTER PACK requested (drug name / strength / formulation [pen, syringe, tablet, etc.]):		**MAINTENANCE product/packaging requested (drug name / strength / formulation [pen, syringe, tablet, etc.]):**	
Quantity per fill:	Refills:	Quantity per fill:	Refills:
Directions:		Directions:	
Diagnosis (*submit documentation*):		Dx code (*required*):	Beneficiary weight:
Is the beneficiary currently being treated with the requested medication?		☐Yes – date of last dose: _____ *Submit documentation.* ☐No	
Is the requested medication prescribed by or in consultation with a specialist (eg, rheumatologist, dermatologist, gastroenterologist, etc.)?		☐Yes ☐No *If prescriber is not a specialist, submit documentation of consultation.*	

Complete all sections that apply to the beneficiary and this request.
Check all that apply and submit documentation for each item.

INITIAL requests

DRUG

1. **Requested drug is NON-PREFERRED on the Statewide PDL:**
   ☐Tried and failed or has a contraindication or intolerance to the preferred drugs in this class approved or medically accepted for the beneficiary's condition *(Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*
2. **Requested drug is BIMZELX (bimekizumab), OTEZLA (apremilast), or SILIQ (brodalumab):**
   ☐Was evaluated for history of prior suicide attempt, bipolar disorder, or major depressive disorder
3. **Requested drug is an ORAL JAK INHIBITOR (eg, Olumiant [baricitinib], Rinvoq [upadacitinib], Xeljanz [tofacitinib]):**
   ☐Tried and failed at least one TNF blocker or other biologic as recommended in the JAK inhibitor's package labeling
   ☐Has a contraindication or an intolerance to TNF blockers or other biologics as recommended in the JAK inhibitor's package labeling

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DIAGNOSIS

1. **ALL diagnoses**:
   - ☐ Screened for hepatitis B virus infection (surface antigen, surface antibody, and core antibody) *(if recommended in the FDA-approved package labeling)*
   - ☐ Screened for tuberculosis *(if recommended in the FDA-approved package labeling)*
2. **Adult-onset Still's disease (AOSD):**
   - ☐ Has predominantly systemic AOSD AND:
     - ☐ Has steroid-dependent AOSD
     - ☐ Tried and failed or has a contraindication or an intolerance to systemic glucocorticoids
   - ☐ Has predominantly joint AOSD AND:
     - ☐ Tried and failed or has a contraindication or an intolerance to conventional DMARDs (eg, MTX)
3. **Alopecia areata:**
   - ☐ Has alopecia universalis
   - ☐ Has >50% scalp involvement or alopecia totalis
   - ☐ Has alopecia that causes significant disability or impaired physical, mental, or psychosocial functioning
   - ☐ Has a current episode of alopecia areata that has lasted at least 6 months
4. **Ankylosing spondylitis & non-radiographic axial spondyloarthritis:**
   - ☐ Tried and failed a 2-week trial of or has a contraindication or an intolerance to 2 different oral NSAIDs
5. **Behçet's syndrome:**
   - ☐ Has recurrent oral ulcers associated with Behçet's syndrome
   - ☐ Tried and failed or has a contraindication or an intolerance to a topical corticosteroid (eg, triamcinolone dental paste)
   - ☐ Tried and failed a 3-month trial of colchicine at maximally tolerated doses or has a contraindication or an intolerance to colchicine
6. **Crohn's disease (CD):**
   - ☐ Has moderate-to-severe CD AND:
     - ☐ Tried and failed to achieve remission with or has a contraindication or an intolerance to an induction course of corticosteroids
     - ☐ Tried and failed to maintain remission with or has a contraindication or an intolerance to conventional immunomodulators (eg, AZA, 6-MP, MTX)
   - ☐ Has CD that is associated with high-risk or poor prognostic features
   - ☐ Has achieved remission with the requested medication AND:
     - ☐ Will be using the requested medication as maintenance therapy to maintain remission
7. **Familial Mediterranean fever:**
   - ☐ Tried and failed a 3-month trial of colchicine at maximally tolerated doses or has a contraindication or an intolerance to colchicine
8. **Generalized pustular psoriasis (GPP):**
   - ☐ Request is for Spevigo (spesolimab) intravenous AND:
     - ☐ Is being treated for a GPP flare
     - ☐ One of the following:
       - ☐ Beneficiary has received a single dose of spesolimab for the current GPP flare AND:
         - ☐ Continues to experience moderate to severe GPP flare symptoms since the previous dose
       - ☐ Beneficiary has not received a dose of spesolimab for the current GPP flare AND:
         - ☐ Is experiencing a moderate to severe GPP flare that warrants rapid stabilization or improvement
   - ☐ Request is for Spevigo (spesolimab) subcutaneous AND:
     - ☐ Has a history of at least one GPP flare
     - ☐ Is using subcutaneous spesolimab for the prevention of GPP flares
9. **Giant cell arteritis (GCA):**
   - ☐ Tried and failed or has a contraindication or an intolerance to systemic glucocorticoids
   - ☐ Is at high risk for glucocorticoid-related complications
   - ☐ Has steroid-dependent GCA
10. **Gout flares:**
    - ☐ Tried and failed maximally tolerated doses of or has a contraindication or an intolerance to NSAIDs
    - ☐ Tried and failed maximally tolerated doses of or has a contraindication or an intolerance to colchicine
    - ☐ Tried and failed maximally tolerated doses of or has a contraindication or an intolerance to corticosteroids
    - ☐ Has a medical reason why repeated courses of corticosteroids are not appropriate
11. **Hidradenitis suppurativa (HS):**
    - ☐ Has Hurley stage II or stage III HS
    - ☐ Is a candidate for or has a history of surgical intervention for HS
    - ☐ Tried and failed a 3-month trial of or has a contraindication or an intolerance to topical clindamycin
    - ☐ Tried and failed or has a contraindication or an intolerance to systemic antibiotics (eg, doxycycline, minocycline, tetracycline, clindamycin)

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12. Juvenile idiopathic arthritis (JIA):
- ☐ Has systemic JIA with active systemic features
- ☐ Has JIA associated with any of the following:
  - ☐ Positive anti-CCP antibodies ☐ Presence of joint damage ☐ High disease activity
  - ☐ Positive rheumatoid factor ☐ High risk of disabling joint damage ☐ Involvement of high-risk joints (cervical spine, hip, wrist)
- ☐ Tried and failed a 3-month trial of or has a contraindication or an intolerance to conventional DMARDs (eg, MTX)
- ☐ Has active sacroiliitis and/or enthesitis AND:
  - ☐ Tried and failed a 2-week trial of or has a contraindication or an intolerance to oral NSAIDs

13. Plaque psoriasis:
- ☐ Has a BSA of ≥3% that is affected
- ☐ Has involvement of critical areas of the body (eg, skin folds, face, genitals)
- ☐ Has psoriasis that causes significant disability or impaired physical, mental, or psychosocial functioning
- ☐ Has moderate-to-severe nail psoriasis
- ☐ Tried and failed a 4-week trial of or has a contraindication or an intolerance to topical corticosteroids
- ☐ Tried and failed an 8-week trial of or has a contraindication or an intolerance to non-steroid topical medications (eg, anthralin, calcineurin inhibitor, tazarotene, etc)

14. Polymyalgia rheumatica (PMR):
- ☐ Tried and failed or has a contraindication or an intolerance to systemic glucocorticoids
- ☐ Has steroid-dependent PMR

15. Psoriatic arthritis (PsA):
- ☐ Tried and failed an 8-week trial of or has a contraindication or an intolerance to conventional DMARDs (eg, AZA, leflunomide, MTX, SSZ)
- ☐ Has predominantly axial PsA, dactylitis, and/or enthesitis
- ☐ Has severe PsA
- ☐ Has comorbid moderate-to-severe nail psoriasis
- ☐ Has comorbid active inflammatory bowel disease

16. Rheumatoid arthritis:
- ☐ Tried and failed a 3-month trial of or has a contraindication or an intolerance to conventional DMARDs (eg, AZA, leflunomide, MTX, etc)

17. Sarcoidosis:
- ☐ Tried and failed or has a contraindication or an intolerance to systemic glucocorticoids
- ☐ Has steroid-dependent sarcoidosis
- ☐ Tried and failed or has a contraindication or an intolerance to conventional DMARDs (eg, AZA, leflunomide, MTX, mycophenolate)

18. Ulcerative colitis (UC):
- ☐ Has moderate-to-severe UC
- ☐ Has UC associated with multiple poor prognostic factors
- ☐ Tried and failed to achieve remission with or has a contraindication or an intolerance to an induction course of corticosteroids
- ☐ Tried and failed to maintain remission with or has a contraindication or an intolerance to conventional immunomodulators (eg, AZA, cyclosporine, 6-MP, MTX)
- ☐ Has achieved remission with the requested medication AND:
  - ☐ Will be using the requested medication as maintenance therapy to maintain remission

19. Uveitis (non-infectious):
- ☐ Has comorbid juvenile idiopathic arthritis
- ☐ Has comorbid Behçet's syndrome
- ☐ Has steroid-dependent uveitis
- ☐ Tried and failed or has a contraindication or an intolerance to systemic, topical, intraocular, or periocular corticosteroids
- ☐ Tried and failed or has a contraindication or an intolerance to conventional systemic immunosuppressives (eg, AZA, MTX, MMF, etc)

20. Other diagnosis: _____
- ☐ List other treatments tried (including start/stop dates, dose, outcomes): _____

_____

RENEWAL requests

- ☐ Experienced an improvement in disease severity or level of functioning since starting therapy with the requested medication
- ☐ Is prescribed an increased dose or more frequent administration of the requested medication
- ☐ **Requested drug is BIMZELX (bimekizumab), OTEZLA (apremilast),** or **SILIQ (brodalumab):**
  - ☐ Was recently reevaluated for behavioral and mood changes

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber Signature:	**Date**: