Cytokine & CAM Antagonists

Please provide the information below, please print your answer, attach supporting documentation, sign, date, and return to our office as soon as possible to expedite this request.
Please FAX responses to: (800) 869-7791. Phone: (855) 322-4082.
Apple Health Preferred Drug List: *https://www.hca.wa.gov/assets/billers-and-providers/apple-health-preferred-drug-list.xlsx*

Date of request:			
Patient	Date of birth	Molina 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:
   ☐ Ankylosing Spondylitis (AS) ☐ Crohn's Disease (CD) ☐ Hidradenitis Suppurativa (HS)
   ☐ Juvenile Idiopathic Arthritis (JIA) ☐ Plaque Psoriasis (Ps) ☐ Psoriatic Arthritis (PsA)
   ☐ Rheumatoid Arthritis (RA) ☐ Ulcerative Colitis (UC)
   ☐ Non-radiographic axial spondyloarthritis
   ☐ Non-infectious Uveitis (UV) classified as intermediate, posterior or panuveitis
   ☐ Other. Specify: _____

4. Has patient tried and failed, has an intolerance or contraindication to any of the following(check all that apply):
   ☐ Acetretin ☐ Corticosteroids ☐ Enbrel (etanercept)
   ☐ Humira (adalimumab) ☐ mesalamine/budesonide MMX ☐ NSAIDs
   ☐ Phototherapy ☐ systemic antibiotics ☐ topical therapies
   ☐ Non-biologic DMARD(s) (azathioprine, cyclosporine, hydroxychloroquine, leflunomide, 6-mercaptopurine, methotrexate, sulfasalazine)
   ☐ Other. Specify: _____

5. Will patient be taking any of the following in combination with this request (mark all that apply)?
   ☐ Biologic DMARD ☐ Phosphodiesterase (PDE 4) inhibitor
   ☐ Janus kinase inhibitor ☐ None

6. Does patient have a negative TB test within the last year? ☐ Yes ☐ No

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

☐ Dermatologist ☐ Gastroenterologist ☐ Ophthalmologist ☐ Rheumatologist ☐ Other. Specify: _____		
CHART NOTES ARE REQUIRED WITH THIS REQUEST		
Prescriber signature	Prescriber specialty	Date