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CardinalCare
Virginia's Medicaid Program

COMMONWEALTH OF VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Service Authorization (SA) Form

Cytokine and CAM Antagonists and Related Agents

If the following information is not complete, correct, or legible, the SA process can be delayed.

Please use one form per member.

MEMBER INFORMATION

Last Name: _____

First Name: _____

Medicaid ID Number: _____

Date of Birth: _____

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name: _____

First Name: _____

NPI Number: _____

Phone Number: _____

Fax Number: _____

DRUG INFORMATION

Does NOT require SA: Enbrel®, Humira®, or infliximab (gen Remicade®)

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

DIAGNOSIS AND MEDICAL INFORMATION

Does the member meet the following criteria?

1. What is the member's diagnosis *(check all that apply)*?
   - ☐ Rheumatoid arthritis (RA)
   - ☐ Adult Crohn's disease (CD)
   - ☐ Pediatric Crohn's disease
   - ☐ Juvenile idiopathic arthritis (JIA)
   - ☐ Psoriatic arthritis (PsA)
   - ☐ Hidradenitis suppurativa (HS)
   - ☐ Ankylosing spondylitis (AS)
   - ☐ Ulcerative colitis (UC)
   - ☐ Uveitis (UV)
   - ☐ Plaque psoriasis (PsO)
   - ☐ Polyarticular juvenile idiopathic arthritis (pJIA)
   - ☐ Disease is classified as moderate to severe
   - ☐ Diagnosis not listed above: _____
2. Does the member have a therapeutic failure to oral methotrexate?
   ☐ Yes ☐ No ☐ N/A
3. Does the member have a therapeutic failure to one of the preferred agents?
   ☐ Yes ☐ No
   If **Yes**, provide details of failure below:
   _____
4. What is the medical necessity that supports the use of the requested medication (provide clinical evidence)?
   _____
   _____

Prescriber Signature (Required) **Date**

By signature, the physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; incomplete forms will delay the SA process.
Submission of documentation does NOT guarantee coverage by the Department of Medical Assistance Services.

The completed form may be **FAXED to 800-932-6651**, phoned to 800-932-6648, or mailed to:
Prime Therapeutics Management LLC/Attn: GV – 4201
P.O. Box 64811, St. Paul, MN 55164-0811