MDwise

Medication Request Form (MRF) for Healthy Indiana Plan (HIP) and Hoosier Healthwise (HHW)

FAX TO: (858) 790-7100

c/o MedImpact Healthcare Systems, Inc.

Attn: Prior Authorization Department

10181 Scripps Gateway Court, San Diego, CA 92131 - Phone: 1-800-788-2949

Instructions:

This form is to be used by participating providers to obtain coverage for the drug listed above which requires *prior authorization*. Please complete this form and fax it to *Med**Impact*** Healthcare Systems, Inc. at (858) 790-7100. If you have any questions regarding this process, please contact Med***Impact***'s Customer Service at (800) 788-2949.

Member/Provider Information:

MDwise Member's Name:	**Provider's Name:**
MDwise Member's ID #:	**Provider's Specialty:**
MDwise Member's DOB (mm-dd-yy):	**Provider's DEA #:** | **Provider's NPI #:**
Pharmacy used by MDwise Member:	**Provider's Telephone Number/Contact Name (xxx-xxx-xxxx):**
Pharmacy Telephone Number (xxx-xxx-xxxx):	**Provider's Fax Number (xxx-xxx-xxxx):**

Clinical Information:

Requested Drug: ☐ **Humira®**	**Dose and Quantity Requested:**
Patient's Current Weight: _____**kg**	**Date weight was measured (mm-dd-yy):** _____
Date Requested:	**Length of Treatment** (*please be specific*)**:**

Documentation of Medical Necessity (please check all that apply, completing all applicable sections):

1. Does the patient have a diagnosis of **moderate to severe polyarticular juvenile idiopathic arthritis (PJIA)**? ☐ Yes ☐ No

AND

Is this for initial therapy (i.e., Is the patient naïve to this medication)? ☐ Yes ☐ No

If no, has the patient experienced or maintained a ≥20% improvement in tender or swollen joint count while on therapy? ☐ Yes ☐ No

AND

Has this treatment been prescribed by or in consultation with a rheumatologist? ☐ Yes ☐ No

AND

Has the patient tried or does the patient have a contraindication to at least **ONE** of the following DMARDs?

methotrexate	☐ Yes	☐ No	If **yes**, describe response/reaction or CI to each medication below:
leflunomide	☐ Yes	☐ No	_____
hydroxychloroquine	☐ Yes	☐ No	_____
sulfasalazine	☐ Yes	☐ No	_____

AND

Has the patient tried Enbrel? ☐ Yes ☐ No If **yes**, describe response/reaction below:

_____

AND

Has the patient tried Orencia SC? ☐ Yes ☐ No If **yes**, describe response/reaction below:

_____

2. Does the patient have a diagnosis of **moderate to severe rheumatoid arthritis**? ☐ Yes ☐ No

AND

Is this for initial therapy (i.e., is the patient currently taking this medication)? ☐ Yes ☐ No

If no, is the request for Humira 40mg dosed **every other week AND**
Has the patient experienced or maintained ≥20% improvement in tender or swollen joint count while on therapy? ☐ Yes ☐ No

OR

If no, is the request for Humira 40mg dosed **weekly AND**
Has the patient tried at least a 3-month regimen of Humira 40mg dosed every other week? ☐ Yes ☐ No

AND

Has the patient experienced or maintained ≥20% improvement in tender or swollen joint count while on therapy? ☐ Yes ☐ No

AND

Has this treatment been prescribed by or in consultation with a rheumatologist? ☐ Yes ☐ No

AND

Has the patient tried or does the patient have a contraindication to at least **ONE** of the following DMARDs?

methotrexate	☐ Yes	☐ No	sulfasalazine	☐ Yes	☐ No
leflunomide	☐ Yes	☐ No	If **yes**, describe response/reaction or CI to each medication below:		
hydroxychloroquine	☐ Yes	☐ No	_____		

AND

Has the patient tried at least **TWO** preferred formulary agents?

Actemra SC	☐ Yes	☐ No	Simponi	☐ Yes	☐ No
Cimzia	☐ Yes	☐ No	Xeljanz/ Xeljanz XR	☐ Yes	☐ No
Enbrel	☐ Yes	☐ No	If **yes**, describe response/reaction to each medication below:		
Orencia SC	☐ Yes	☐ No	_____		

3. Does the patient have a diagnosis of **psoriatic arthritis**? ☐ Yes ☐ No

AND

Is this for initial therapy (i.e., Is the patient naïve to this medication)? ☐ Yes ☐ No

If no, has the patient experienced or maintained a ≥20% improvement in tender or swollen joint count while on therapy? ☐ Yes ☐ No

AND

Has this treatment been prescribed by or in consultation with a rheumatologist or a dermatologist? ☐ Yes ☐ No

AND

Has the patient tried or does the patient have a contraindication to at least one of the following DMARDs?

methotrexate	☐ Yes	☐ No	sulfasalazine	☐ Yes	☐ No
leflunomide	☐ Yes	☐ No	If **yes**, describe response/reaction or CI to each medication below:		
hydroxychloroquine	☐ Yes	☐ No	_____		

AND

Has the patient tried at least **TWO** preferred formulary agents?

Cimzia	☐ Yes	☐ No	Otezla	☐ Yes	☐ No
Cosentyx	☐ Yes	☐ No	Simponi	☐ Yes	☐ No
Enbrel	☐ Yes	☐ No	Xeljanz/ Xeljanz XR	☐ Yes	☐ No
Orencia SC	☐ Yes	☐ No	If **yes**, describe response/reaction to each medication below:		

_____

4. Does the patient have a diagnosis of **ankylosing spondylitis**? ☐ Yes ☐ No

AND

Is this for initial therapy (i.e., Is the patient naïve to this medication)? ☐ Yes ☐ No

If no, has the patient experienced or maintained an improvement of ≥50% or 2 units (scale of 1-10) in the Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) while on therapy? ☐ Yes ☐ No

AND

Has this treatment been prescribed by or in consultation with a rheumatologist? ☐ Yes ☐ No

AND

Has the patient tried at least **TWO** preferred formulary agents?

Cimzia	☐ Yes	☐ No	Enbrel	☐ Yes	☐ No
Cosentyx	☐ Yes	☐ No	Simponi	☐ Yes	☐ No

If **yes**, describe response/reaction to each medication below:

_____

5. Does the patient have a diagnosis of **moderate to severe Crohn's disease**? ☐ Yes ☐ No

AND

Is this for initial therapy (i.e., Is the patient naïve to this medication)? ☐ Yes ☐ No

If no, has the patient achieved or maintained symptomatic improvement or a decrease in PCDAI (Pediatric Crohn's Disease Activity Index) of at least 15 points or decrease in CDAI (Crohn's Disease Activity Index) of at least 70 points while on therapy? ☐ Yes ☐ No

AND

Has this treatment been prescribed by or in consultation with a gastroenterologist? ☐ Yes ☐ No

AND

Has the patient tried at least **ONE** conventional agent? Some examples include:

corticosteroids	☐ Yes	☐ No	**If yes**, describe the response/reaction to each treatment below:
azathioprine	☐ Yes	☐ No	_____
mercaptopurine	☐ Yes	☐ No	_____
methotrexate	☐ Yes	☐ No	_____
mesalamine	☐ Yes	☐ No	_____

AND

If age 18 or older, has the patient tried Cimzia? ☐ Yes ☐ No

If **yes**, describe response/reaction: _____

6. Does the patient have a diagnosis of **moderate to severe ulcerative colitis**? ☐ Yes ☐ No

AND

Is this for initial therapy (i.e., Is the patient naïve to this medication)? ☐ Yes ☐ No

If no, has the patient achieved or maintained symptomatic improvement while on therapy? ☐ Yes ☐ No

AND

Has this treatment been prescribed by or in consultation with a gastroenterologist? ☐ Yes ☐ No

AND

Has the patient tried at least **ONE** conventional agent? Some examples include:

corticosteroids	☐ Yes	☐ No	**If yes**, please describe the response/reaction to each treatment below:
azathioprine	☐ Yes	☐ No	_____
mercaptopurine	☐ Yes	☐ No	_____
methotrexate	☐ Yes	☐ No	_____
mesalamine	☐ Yes	☐ No	_____

AND

Has the patient tried Simponi? ☐ Yes ☐ No

If **yes**, describe response/reaction: _____

7. Does the patient have a diagnosis of **moderate to severe hidradenitis suppurativa**? ☐ Yes ☐ No

AND

Is this for initial therapy (i.e., Is the patient naïve to this medication)? ☐ Yes ☐ No

If no, has the patient experienced at least 50% reduction in total abscess and inflammatory nodule count while on therapy? ☐ Yes ☐ No

AND

Has this treatment been prescribed by or in consultation with a dermatologist? ☐ Yes ☐ No

8. Does the patient have a diagnosis of **non-infectious intermediate, posterior and panuveitis**? ☐ Yes ☐ No

AND

Is this for initial therapy (i.e., Is the patient naïve to this medication)? ☐ Yes ☐ No

If no, is the patient free from treatment failure, defined as one of the following:

- Development of new inflammatory chorioretinal or retinal vascular lesions
- A 2-step increase from baseline in anterior chamber cell grade or vitreous haze grade
- A worsening of best corrected visual acuity (BCVA) by at least 15 letters relative to best state achieved? ☐ Yes ☐ No

AND

Does the patient have isolated interior uveitis? ☐ Yes ☐ No

AND

Has this treatment been prescribed by or in consultation with an ophthalmologist? ☐ Yes ☐ No

9. Does the patient have a diagnosis of **moderate to severe plaque psoriasis**? ☐ Yes ☐ No

AND

Is this for initial therapy (i.e., is patient naïve to this medication)? ☐ Yes ☐ No

If no, did the patient achieve or maintain clear or minimal disease or experience a decrease in PASI (Psoriasis Area and Severity Index) of at least 50% or more while on therapy? ☐ Yes ☐ No

AND

Has this treatment been prescribed by or in consultation with a dermatologist? ☐ Yes ☐ No

AND

Does the plaque psoriasis involve at least 10% body surface area (BSA) or do the psoriatic lesions affect the face, hands, feet, or genital area? ☐ Yes ☐ No

AND

Has the patient tried or have a contraindication to at least **ONE** of the following preferred therapies?

PUVA (Phototherapy Ultraviolet Light A) ☐ Yes ☐ No

UVB (Ultraviolet Light B) ☐ Yes ☐ No **If yes**, describe the response/reaction or CI to each treatment below:

topical corticosteroids ☐ Yes ☐ No _____

acitretin ☐ Yes ☐ No _____

calcipotriene ☐ Yes ☐ No _____

methotrexate ☐ Yes ☐ No _____

cyclosporine ☐ Yes ☐ No _____

AND

Has the patient tried at least **TWO** preferred formulary agents?

Cosentyx ☐ Yes ☐ No

Enbrel ☐ Yes ☐ No

Cimzia ☐ Yes ☐ No

Otezla ☐ Yes ☐ No

If **yes**, describe response/reaction to each medication below:

10. Please attach additional information which may indicate ***why this specific medication*** is being requested for this patient.