



**Cyltezo® Prior Authorization Request Form (Page 1 of 2)**

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<b>Member Information</b> (required)				<b>Provider Information</b> (required)		
Member Name:				Provider Name:		
Insurance ID#:				NPI#:		Specialty:
Date of Birth:				Office Phone:		
Street Address:				Office Fax:		
City:	State:	Zip:		Office Street Address:		
Phone:				City:	State:	Zip:
<b>Medication Information</b> (required)						
Medication Name:				Strength:		Dosage Form:
<input type="checkbox"/> Check if requesting <b>brand</b>				Directions for Use:		
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>						
<b>Clinical Information</b> (required)						
<b>Select the diagnosis below:</b> <input type="checkbox"/> Active ankylosing spondylitis <input type="checkbox"/> Active psoriatic arthritis (PsA) <input type="checkbox"/> Moderate to severe chronic plaque psoriasis <input type="checkbox"/> Moderately to severely active Crohn's disease <input type="checkbox"/> Moderately to severely active polyarticular juvenile idiopathic arthritis (JIA) <input type="checkbox"/> Moderately to severely active rheumatoid arthritis (RA) <input type="checkbox"/> Moderately to severely active ulcerative colitis <input type="checkbox"/> Hidradenitis Suppurativa <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____						
<b>Clinical information:</b> Select if the requested medication is prescribed by or in consultation with one of the following specialists: <input type="checkbox"/> Dermatologist <input type="checkbox"/> Gastroenterologist <input type="checkbox"/> Ophthalmologist <input type="checkbox"/> Rheumatologist <input type="checkbox"/> Other _____ Will the requested medication be used in combination with another biologic agent or targeted immunomodulator? <input type="checkbox"/> Yes <input type="checkbox"/> No						
<b>Justification for the use of a non-preferred product (Cyltezo) over a preferred product (Humira):</b> If non-preferred agent is medically necessary or required, provide a brief summary for use of the non-preferred agent over a preferred alternative: _____ _____						
<b>For active ankylosing spondylitis (AS), also answer the following:</b> Has the patient had an inadequate response to, intolerance to, or contraindication to one or more non-steroidal anti-inflammatory drugs (NSAIDs)? <input type="checkbox"/> Yes <input type="checkbox"/> No   List _____						
<b>For active psoriatic arthritis (PsA), also answer the following:</b> Has the patient had an inadequate response to, intolerance to, or contraindication to methotrexate? <input type="checkbox"/> Yes <input type="checkbox"/> No						
<b>For moderate to severe chronic plaque psoriasis (PsO), also answer the following:</b> Has the patient had an inadequate response to, intolerance to, or contraindication to conventional therapy with at least one of the following: phototherapy or one or more oral systemic treatments (i.e., methotrexate, calcipotriene, cyclosporine, acitretin, sulfasalazine, tazarotene, corticosteroid)? <input type="checkbox"/> Yes <input type="checkbox"/> No   List _____						

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**For moderately to severely active Crohn's disease, also answer the following:**

Has the patient had an inadequate response to, intolerance to, or contraindication to one or more immunosuppressive agents (e.g., azathioprine, mercaptopurine, methotrexate)? ☐ **Yes** ☐ **No** List \_\_\_\_\_

**For moderately to severely active polyarticular juvenile idiopathic arthritis (pJIA), also answer the following:**

Has the patient had an inadequate response to, intolerance to, or contraindication to one or more non-biologic disease modifying anti-rheumatic drugs (DMARDs)? ☐ **Yes** ☐ **No** List \_\_\_\_\_

**For moderately to severely active rheumatoid arthritis (RA), also answer the following:**

Has the patient had an inadequate response to, intolerance to, or contraindication to one or more non-biologic disease modifying anti-rheumatic drugs (DMARDs)? ☐ **Yes** ☐ **No** List \_\_\_\_\_

**For moderately to severely active ulcerative colitis, also answer the following:**

Has the patient had an inadequate response to, intolerance to, or contraindication to conventional therapy with one or more of the following: corticosteroids (i.e., prednisone, methylprednisolone), 5-ASAs (i.e., mesalamine, sulfasalazine, balsalazide, olsalazine), non-biologic DMARDs (i.e., azathioprine, methotrexate, mercaptopurine)? ☐ **Yes** ☐ **No** List \_\_\_\_\_

**For moderate to severe hidradenitis suppurativa, also answer the following:**

Has the patient had an inadequate response to, intolerance to, or contraindication to one or more of the following: oral or topical antibiotic therapy OR oral retinoid therapy, dapson, or acitretin? ☐ **Yes** ☐ **No** List \_\_\_\_\_

**For non-infectious uveitis, also answer the following:**

Has the patient had an inadequate response to, intolerance to, or contraindication to one or more of the following: methotrexate, mycophenolate, azathioprine, cyclosporine, tacrolimus, cyclophosphamide, oral/injectable steroid therapy? ☐ **Yes** ☐ **No**  
List \_\_\_\_\_

**Quantity limit requests:**

What is the quantity requested per TREATMENT? \_\_\_\_\_ syringe every \_\_\_\_\_ weeks

**What is the reason for exceeding the plan limitations?**

- ☐ Titration or loading dose purposes  
☐ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)  
☐ Requested strength/dose is not commercially available  
☐ Other: \_\_\_\_\_

**Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?**

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Please note:

This request may be denied unless all required information is received.  
For urgent or expedited requests please call 1-855-401-4262.  
This form may be used for non-urgent requests and faxed to 1-844-403-1029.

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