South Dakota Department of Social Services

Please note: All information below is required to process this request.
Fax to 1-844-403-1029
Mon-Sat: 7am to 7pm Central

Hyrimoz® Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

- ❑ Active ankylosing spondylitis
- ❑ Active psoriatic arthritis (PsA)
- ❑ Moderate to severe chronic plaque psoriasis
- ❑ Moderately to severely active Crohn's disease
- ❑ Moderately to severely active polyarticular juvenile idiopathic arthritis (JIA)
- ❑ Moderately to severely active rheumatoid arthritis (RA)
- ❑ Moderately to severely active ulcerative colitis
- ❑ Moderately to severely active ulcerative colitis
- ❑ Hidradenitis Suppurativa
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Select if the requested medication is prescribed by or in consultation with one of the following specialists:
❑ Dermatologist ❑ Gastroenterologist ❑ Ophthalmologist ❑ Rheumatologist ❑ Other _____

Will the requested medication be used in combination with another biologic agent or targeted immunomodulator? ❑ **Yes** ❑ **No**

Justification for the use of a non-preferred product (Hymiroz) over a preferred product (Humira):

If non-preferred agent is medically necessary or required, provide a brief summary for use of the non-preferred agent over a preferred alternative: _____

_____

For active ankylosing spondylitis (AS), also answer the following:

Has the patient had an inadequate response to, intolerance to, or contraindication to one or more non-steroidal anti-inflammatory drugs (NSAIDs)? ❑ **Yes** ❑ **No** List _____

For active psoriatic arthritis (PsA), also answer the following:

Has the patient had an inadequate response to, intolerance to, or contraindication to methotrexate? ❑ **Yes** ❑ **No**

For moderate to severe chronic plaque psoriasis (PsO), also answer the following:

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, cyclosporine, acitretin, sulfasalazine, calcipotriene, tazarotene, corticosteroid)? ❑ **Yes** ❑ **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, dapsone, 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?

_____

_____

_____

_____

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.