



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: (800) 213-5525, Option 1-2-2.

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? 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
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