

**CYTOKINE AND
CAM ANTAGONISTS
PRIOR AUTHORIZATION FORM**
(form effective 1/5/2026)



Keystone First

PERFORMRxSM
Next Generation Pharmacy Benefits

Fax to PerformRxSM at **1-866-497-1387**, or to speak to a representative call **1-800-588-6767**.

PRIOR AUTHORIZATION REQUEST INFORMATION			
<input type="checkbox"/> New request <input type="checkbox"/> Renewal request		Total # of pages:	
Name of office contact:		Contact's phone number:	
LTC facility contact/phone:			
PATIENT INFORMATION			
Patient name:		Patient ID #:	DOB:
Street address:			
Apt #:	City/state/zip:		Phone:
PRESCRIBER INFORMATION			
Prescriber name:			
Specialty:		NPI:	State license #:
Street address:			
Suite #:	City/state/zip:		
Phone:		Fax:	
CLINICAL INFORMATION			
Medication requested:			
Preferred Medication:			
Adalimumab High Concentration Products:	Ustekinumab Products:		
<input type="checkbox"/> Adalimumab-aaty(CF) 100 mg/mL Autoinjector	<input type="checkbox"/> Pyzchiva (ustekinumab-ttwe) Syringe	<input type="checkbox"/> Simponi (golimumab) Pen	
<input type="checkbox"/> Adalimumab-aaty(CF) 100 mg/mL Syringe	<input type="checkbox"/> Pyzchiva (ustekinumab-ttwe) Vial	<input type="checkbox"/> Simponi (golimumab) Syringe	
<input type="checkbox"/> Simlandi(CF) (adalimumab-ryvk) 100 mg/mL Autoinjector	<input type="checkbox"/> Avsola (infliximab-axxq) Vial	<input type="checkbox"/> Skyrizi (risankizumab-rzaa) On-Body Injector	
<input type="checkbox"/> Simlandi(CF) (adalimumab-ryvk) 100 mg/mL Syringe	<input type="checkbox"/> Enbrel (etanercept) Mini Cartridge	<input type="checkbox"/> Skyrizi (risankizumab-rzaa) Pen	
<input type="checkbox"/> Adalimumab Low Concentration Products:	<input type="checkbox"/> Enbrel (etanercept) Sureclick Pen	<input type="checkbox"/> Skyrizi (risankizumab-rzaa) Syringe	
<input type="checkbox"/> Adalimumab-fkjp(CF) 50 mg/mL Pen	<input type="checkbox"/> Enbrel (etanercept) Syringe	<input type="checkbox"/> Taltz (ixekizumab) Autoinjector	
<input type="checkbox"/> Adalimumab-fkjp(CF) 50 mg/mL Syringe	<input type="checkbox"/> Enbrel (etanercept) Vial	<input type="checkbox"/> Taltz (ixekizumab) Syringe	
<input type="checkbox"/> Hadlima (adalimumab-bwwd) 50 mg/mL Pushtouch	<input type="checkbox"/> Infliximab Vial (Janssen's unbranded infliximab)	<input type="checkbox"/> Tyenne (tocilizumab-aazg) Autoinjector	
<input type="checkbox"/> Hadlima (adalimumab-bwwd) 50 mg/mL Syringe	<input type="checkbox"/> Kineret (anakinra) Syringe	<input type="checkbox"/> Tyenne (tocilizumab-aazg) Syringe	
	<input type="checkbox"/> Orencia (abatacept) Clickjet	<input type="checkbox"/> Tyenne (tocilizumab-aazg) Vial	
	<input type="checkbox"/> Orencia (abatacept) Vial	<input type="checkbox"/> Xeljanz (tofacitinib) Solution	
	<input type="checkbox"/> Otezla (apremilast) Tablet	<input type="checkbox"/> Xeljanz (tofacitinib) Tablet	
		<input type="checkbox"/> Xeljanz XR (tofacitinib) Tablet	
Medication requested:			
Non-Preferred Medication:			
Adalimumab High Concentration Products:	<input type="checkbox"/> Hyrimoz(CF) (adalimumab-adaz) 100 mg/mL Pen	<input type="checkbox"/> Hulio(CF) (adalimumab-fkjp) 50 mg/mL Pen	<input type="checkbox"/> Ustekinumab Vial (Janssen's unbranded ustekinumab)
<input type="checkbox"/> Adalimumab-adaz(CF) 100 mg/mL Pen	<input type="checkbox"/> Hyrimoz(CF) (adalimumab-adaz) 100 mg/mL Syringe	<input type="checkbox"/> Hulio(CF) (adalimumab-fkjp) 50 mg/mL Syringe	<input type="checkbox"/> Ustekinumab-aekn Syringe
<input type="checkbox"/> Adalimumab-adaz(CF) 100 mg/mL Syringe	<input type="checkbox"/> Yuflyma(CF) (adalimumab-aaty) 100 mg/mL Autoinjector	<input type="checkbox"/> Humira (adalimumab) 50 mg/mL Pen	<input type="checkbox"/> Ustekinumab-ttwe Syringe
<input type="checkbox"/> Adalimumab-adbm(CF) 100 mg/mL Pen	<input type="checkbox"/> Yuflyma(CF) (adalimumab-aaty) 100 mg/mL Syringe	<input type="checkbox"/> Humira (adalimumab) 50 mg/mL Syringe	<input type="checkbox"/> Ustekinumab-ttwe Vial
<input type="checkbox"/> Adalimumab-adbm(CF) 100 mg/mL Syringe		<input type="checkbox"/> Idacio(CF) (adalimumab-aacf) 50 mg/mL Pen	<input type="checkbox"/> Yesintek (ustekinumab-kfce) Syringe
<input type="checkbox"/> Adalimumab-ryvk(CF) 100 mg/mL Autoinjector	Adalimumab Low Concentration Products:	<input type="checkbox"/> Idacio(CF) (adalimumab-aacf) 50 mg/mL Syringe	<input type="checkbox"/> Yesintek (ustekinumab-kfce) Vial
<input type="checkbox"/> Adalimumab-ryvk(CF) 100 mg/mL Syringe	<input type="checkbox"/> Abrilada(CF) (adalimumab-afzb) 50 mg/mL Pen	<input type="checkbox"/> Yusimry(CF) (adalimumab-aqvh) 50 mg/mL Pen	
<input type="checkbox"/> Amjevita(CF) (adalimumab-atto) 100 mg/mL Autoinjector	<input type="checkbox"/> Abrilada(CF) (adalimumab-afzb) 50 mg/mL Syringe		
<input type="checkbox"/> Amjevita(CF) (adalimumab-atto) 100 mg/mL Syringe	<input type="checkbox"/> Adalimumab-aacf(CF) 50 mg/mL Pen	Ustekinumab Products:	
<input type="checkbox"/> Cyltezo(CF) (adalimumab-adbm) 100 mg/mL Pen	<input type="checkbox"/> Adalimumab-aacf(CF) 50 mg/mL Syringe	<input type="checkbox"/> Imuldosa (ustekinumab-srif) Syringe	
<input type="checkbox"/> Cyltezo(CF) (adalimumab-adbm) 100 mg/mL Syringe	<input type="checkbox"/> Adalimumab-adbm(CF) 50 mg/mL Pen	<input type="checkbox"/> Imuldosa (ustekinumab-srif) Vial	
<input type="checkbox"/> Hadlima(CF) (adalimumab-bwwd) 100 mg/mL Pushtouch	<input type="checkbox"/> Adalimumab-adbm(CF) 50 mg/mL Syringe	<input type="checkbox"/> Otulfi (ustekinumab-aaaz) Syringe	
<input type="checkbox"/> Hadlima(CF) (adalimumab-bwwd) 100 mg/mL Syringe	<input type="checkbox"/> Amjevita(CF) (adalimumab-atto) 50 mg/mL Autoinjector	<input type="checkbox"/> Otulfi (ustekinumab-aaaz) Vial	
<input type="checkbox"/> Humira(CF) (adalimumab) 100 mg/mL Pen	<input type="checkbox"/> Amjevita(CF) (adalimumab-atto) 50 mg/mL Syringe	<input type="checkbox"/> Selarsdi (ustekinumab-aekn) Syringe	
<input type="checkbox"/> Humira(CF) (adalimumab) 100 mg/mL Syringe	<input type="checkbox"/> Cyltezo(CF) (adalimumab-adbm) 50 mg/mL Pen	<input type="checkbox"/> Selarsdi (ustekinumab-aekn) Vial	
	<input type="checkbox"/> Cyltezo(CF) (adalimumab-adbm) 50 mg/mL Syringe	<input type="checkbox"/> Stelara (ustekinumab) Syringe	
		<input type="checkbox"/> Stelara (ustekinumab) Vial	
		<input type="checkbox"/> Steqeyma (ustekinumab-stba) Syringe	
		<input type="checkbox"/> Steqeyma (ustekinumab-stba) Vial	
		<input type="checkbox"/> Ustekinumab Syringe (Janssen's unbranded ustekinumab)	

CLINICAL INFORMATION**Medication requested:****Other Products:**

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Actemra (tocilizumab) Actpen | <input type="checkbox"/> Entyvio (vedolizumab) Pen | <input type="checkbox"/> Omvoh (mirikizumab-mrkz) Syringe | <input type="checkbox"/> Tofidence (tocilizumab-bavi) Vial |
| <input type="checkbox"/> Actemra (tocilizumab) Syringe | <input type="checkbox"/> Entyvio (vedolizumab) Vial | <input type="checkbox"/> Omvoh (mirikizumab-mrkz) Vial | <input type="checkbox"/> Tremfya (guselkumab) One-Press Autoinjector |
| <input type="checkbox"/> Actemra (tocilizumab) Vial | <input type="checkbox"/> Ilaris (canakinumab) Vial | <input type="checkbox"/> Orencia (abatacept) Syringe | <input type="checkbox"/> Tremfya (guselkumab) Pen |
| <input type="checkbox"/> Arcalyst (rilonacept) Vial | <input type="checkbox"/> Ilumya (tildrakizumab) Syringe | <input type="checkbox"/> Remicade (infliximab) Vial | <input type="checkbox"/> Tremfya (guselkumab) Syringe |
| <input type="checkbox"/> Bimzelx (bimekizumab-bkzx) Autoinjector | <input type="checkbox"/> Inflectra (infliximab-dyyb) Vial | <input type="checkbox"/> Renflexis (infliximab-abda) Vial | <input type="checkbox"/> Tremfya (guselkumab) Vial |
| <input type="checkbox"/> Bimzelx (bimekizumab-bkzx) Syringe | <input type="checkbox"/> Kevzara (sarilumab) Pen | <input type="checkbox"/> Rinvoq ER (upadacitinib) Tablet | <input type="checkbox"/> Zymfentra (infliximab-dyyb) Pen |
| <input type="checkbox"/> Cimzia (certolizumab pegol) Syringe | <input type="checkbox"/> Kevzara (sarilumab) Syringe | <input type="checkbox"/> Rinvoq LQ (upadacitinib) Solution | <input type="checkbox"/> Zymfentra (infliximab-dyyb) Syringe |
| <input type="checkbox"/> Cosentyx (secukinumab) Sensoready Pen | <input type="checkbox"/> Leqselvi (deuruxolitinib) Tablet | <input type="checkbox"/> Simponi Aria (golimumab) Vial | |
| <input type="checkbox"/> Cosentyx (secukinumab) Syringe | <input type="checkbox"/> Litfulo (ritilecitinib) Capsule | <input type="checkbox"/> Sotyktu (deucravacitinib) Tablet | |
| <input type="checkbox"/> Cosentyx (secukinumab) Unoready Pen | <input type="checkbox"/> Olumiant (baricitinib) Tablet | <input type="checkbox"/> Spevigo (spesolimab-sbzo) Syringe | |
| <input type="checkbox"/> Cosentyx (secukinumab) Vial | <input type="checkbox"/> Omvoh (mirikizumab-mrkz) Pen | <input type="checkbox"/> Spevigo (spesolimab-sbzo) Vial | |

STARTER PACK requested (strength/formulation):

MAINTENANCE product/packaging requested (strength/formulation):

Quantity per fill:

Refills:

Quantity per fill:

Refills:

Directions:

Directions:

Diagnosis (*submit documentation*):

Dx code (required):

Beneficiary weight:

Is the beneficiary currently being treated with the requested medication?

- Yes – date of last dose: _____ *Submit documentation.*
 No

Is the requested medication prescribed by or in consultation with a specialist (e.g., rheumatologist, dermatologist, gastroenterologist, etc)?

- Yes *If prescriber is not a specialist, submit documentation of consultation.*
 No

PHARMACY INFORMATION (Prescriber to identify the pharmacy that is to dispense the medication):Deliver to: Patient's Home Physician's Office Patient's Preferred Pharmacy Name:

NPI#:

Pharmacy Phone #:

Pharmacy Fax #:

 I acknowledge that the patient agrees with the pharmacy chosen for delivery of this medication.

**Complete all sections that apply to the beneficiary and this request.
 Check all that apply and submit documentation for each item.**

INITIAL REQUESTS**Drug****1. Requested drug is NON-PREFERRED:**

- Tried and failed or has a contraindication or intolerance to the preferred drugs in this class approved or medically accepted for the beneficiary's condition.
 List preferred medications tried: _____

2. Requested drug is NON-PREFERRED with a therapeutically equivalent brand/generic or corresponding biosimilar/brand biologic/unbranded biologic that is preferred:

- Tried and failed or has a contraindication or intolerance to the preferred therapeutically equivalent brand/generic or corresponding biosimilar/brand biologic/unbranded biologic that would not be expected to occur with the requested drug.
 List preferred therapeutically equivalent medications tried: _____

3. Requested drug is BIMZELX (bimekizumab), OTEZLA (apremilast), or SILIQ (brodalumab):

- Was evaluated for history of prior suicide attempt, bipolar disorder, or major depressive disorder

4. Requested drug is an oral JAK inhibitor (eg, Olumiant [baricitinib], Rinvoq [upadacitinib], Xeljanz [tofacitinib]):

- Tried and failed at least one TNF blocker or another biologic as recommended in the JAK inhibitor's package labeling
 Has a contraindication or an intolerance to TNF blockers or other biologics as recommended in the JAK inhibitor's package labeling

Diagnosis**1. ALL diagnoses:**

- Screened for hepatitis B virus infection (surface antigen, surface antibody, and core antibody) (if recommended in the FDA-approved package labeling)
 Screened for tuberculosis (if recommended in the FDA-approved package labeling)

2. Adult-onset Still's disease:

- Has predominantly systemic disease:
 Has steroid-dependent disease with intent to decrease or discontinue dose of steroid with use of Cytokine and CAM Antagonist
 Tried and failed or has a contraindication or an intolerance to systemic glucocorticoids
 Has predominantly joint disease:
 Tried and failed or has a contraindication or an intolerance to conventional DMARDs (eg, MTX)

3. Alopecia areata:

- Has alopecia universalis
 Has >50% scalp involvement or alopecia totalis
 Has alopecia that causes significant disability or impaired physical, mental, or psychosocial functioning
 Has a current episode of alopecia areata that has lasted at least 6 months

4. Ankylosing spondylitis & non-radiographic axial spondyloarthritis:

- Tried and failed a 2-week trial of or has a contraindication or an intolerance to 2 different oral NSAIDs

INITIAL REQUESTS (continued)**5. Behçet's syndrome:**

- Has a diagnosis of Behçet's syndrome according to current consensus guidelines
- Has recurrent oral ulcers associated with Behçet's syndrome
- Tried and failed or has a contraindication or an intolerance to a topical corticosteroid (eg, triamcinolone dental paste)
- Tried and failed a 3-month trial of or has a contraindication or an intolerance to colchicine at maximally tolerated doses

6. Crohn's disease:

- Has moderate-to-severe disease
- Has disease that is associated with high-risk or poor prognostic features

7. Familial Mediterranean fever:

- Tried and failed a 3-month trial of or has a contraindication or an intolerance to colchicine at maximally tolerated doses

8. Generalized pustular psoriasis (GPP) flares:

- Request is for Spevigo (spesolimab) intravenous:
 - Is being treated for a GPP flare
 - One of the following:
 - Beneficiary has received a single dose of spesolimab for the current GPP flare AND:
 - Continues to experience moderate to severe GPP flare symptoms since the previous dose
 - Beneficiary has not received a dose of spesolimab for the current GPP flare AND:
 - Is experiencing a moderate to severe GPP flare that warrants rapid stabilization or improvement
- Request is for Spevigo (spesolimab) subcutaneous:
 - Has a history of at least one GPP flare
 - Is using subcutaneous spesolimab for the prevention of GPP flares

9. Giant cell arteritis:

- Tried and failed or has a contraindication or an intolerance to systemic glucocorticoids
- Is at high risk for glucocorticoid-related complications
- Has steroid-dependent disease with intent to decrease or discontinue dose of steroid with use of Cytokine and CAM Antagonist

10. Gout flare:

- Tried and failed maximally tolerated doses of or has a contraindication or an intolerance to NSAIDs
- Tried and failed maximally tolerated doses of or has a contraindication or an intolerance to colchicine
- Tried and failed maximally tolerated doses of or has a contraindication or an intolerance to corticosteroids
- Has a medical reason why repeated courses of corticosteroids are not appropriate

11. Hidradenitis suppurativa (HS):

- Has Hurley stage II or stage III disease
- Is a candidate for or has a history of surgical intervention for HS
- Tried and failed a 3-month trial of or has a contraindication or an intolerance to topical clindamycin
- Tried and failed or has a contraindication or an intolerance to systemic antibiotics (e.g., doxycycline, minocycline, tetracycline, clindamycin)

12. Juvenile idiopathic arthritis:

- Has systemic disease with active systemic features
- Has disease associated with any of the following:
 - Positive anti-CCP antibodies
 - Positive rheumatoid factor
 - Presence of joint damage
 - At high risk of disabling joint damage
 - High disease activity
 - Involvement of high-risk joints (cervical spine, hip, wrist)
- Tried and failed a 3-month trial of or has a contraindication or an intolerance to conventional DMARDs (e.g., MTX)
- Has active sacroiliitis and/or enthesitis:
 - Tried and failed a 2-week trial of or has a contraindication or an intolerance to oral NSAIDs

13. Plaque psoriasis:

- Has a BSA of $\geq 3\%$ that is affected
- Has involvement of critical areas of the body (eg, skin folds, face, genitals)
- Has psoriasis that causes significant disability or impaired physical, mental, or psychosocial functioning
- Has moderate-to-severe nail disease
- Tried and failed a 4-week trial of or has a contraindication or an intolerance to topical corticosteroids
- Tried and failed an 8-week trial of or has a contraindication or an intolerance to non-steroid topical medications (e.g., anthralin, calcineurin inhibitor, tazarotene, etc)

14. Polymyalgia rheumatica:

- Tried and failed or has a contraindication or an intolerance to systemic glucocorticoids
- Has steroid-dependent disease with intent to decrease or discontinue dose of steroid with use of Cytokine and CAM Antagonist

15. Psoriatic arthritis:

- Tried and failed an 8-week trial of or has a contraindication or an intolerance to conventional DMARDs (e.g., AZA, leflunomide, MTX, SSZ)
- Has predominantly axial disease, dactylitis, and/or enthesitis
- Has severe disease
- Has comorbid moderate-to-severe nail psoriasis
- Has comorbid active inflammatory bowel disease

16. Rheumatoid arthritis:

- Tried and failed a 3-month trial of or has a contraindication or an intolerance to conventional DMARDs (e.g., AZA, leflunomide, MTX, etc.)

17. Sarcoidosis:

- Tried and failed or has a contraindication or an intolerance to systemic glucocorticoids
- Has steroid-dependent disease
- Tried and failed or has a contraindication or an intolerance to a conventional DMARD (e.g., AZA, leflunomide, MTX, mycophenolate)

INITIAL REQUESTS (continued)

18. Ulcerative colitis:

- Has moderate-to-severe disease
- Has disease associated with multiple poor prognostic factors

19. Uveitis (non-infectious):

- Has comorbid juvenile idiopathic arthritis
- Has comorbid Behçet's syndrome
- Has steroid-dependent disease with intent to decrease or discontinue dose of steroid with use of Cytokine and CAM Antagonist
- Tried and failed or has a contraindication or an intolerance to systemic, topical, intraocular, or periocular corticosteroids
- Tried and failed or has a contraindication or an intolerance to conventional systemic immunosuppressives (e.g., AZA, MTX, MMF, etc.)

20. Other diagnosis:

- List other treatments tried (including start/stop dates, dose, outcomes):

RENEWAL REQUESTS

- Experienced an improvement in disease severity or level of functioning since starting therapy with the requested medication
- Is prescribed an increased dose or more frequent administration of the requested medication that is supported by peer-reviewed medical literature or national treatment guidelines
- Requested drug is BIMZELX (bimekizumab), OTEZLA (apremilast), or SILIQ (brodalumab):**
 - Was recently reevaluated for behavioral and mood changes
- Requested drug is NON-PREFERRED with a therapeutically equivalent brand/generic or corresponding biosimilar/brand biologic/unbranded biologic that is preferred:**
- Tried and failed or has a contraindication or intolerance to the preferred therapeutically equivalent brand/generic or corresponding biosimilar/brand biologic/unbranded biologic that would not be expected to occur with the requested drug.
- List preferred therapeutically equivalent medication(s) tried:

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date:
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