HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
ACNE VULGARIS AND ROSACEA

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Please note the following do not require prior authorization: adapalene, azelaic acid, topical antibiotics, topical benzoyl peroxide, topical metronidazole, topical retinoids

Product being requested: _____
Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
Acne Vulgaris			
1. Does the member have a diagnosis of acne vulgaris?	☐	☐	**Please provide documentation**
2. Does documentation show that the member has tried and failed ALL of the following categories: • topical benzoyl peroxide • topical or oral antibiotic (e.g. clindamycin, sulfacetamide, erythromycin) • topical retinoid (e.g. adapalene, tretinoin, tazarotene) • Topical generic dapsone or tazarotene	☐	☐	**Please provide documentation**
Rosacea			
1. Does the member have a diagnosis of rosacea?	☐	☐	**Please provide documentation**
2. Does documentation show that the member has failed a trial of a topical metronidazole agent, a topical generic azelaic acid and ivermectin cream?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member's therapy been re-evaluated within the past 12 months?	☐	☐	

3. Does the member show a continued medical need for the therapy?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.
Additional information:
Physician's Signature:

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-001
Origination Date: 01/01/2022
Reviewed/Revised Date: 05/27/2025
Next Review Date: 05/27/2026
Current Effective Date: 06/01/2025

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
ALPHA- 1 PROTEINASE INHIBITORS
Aralast NP®, Glassia®, Prolastin-C®, Zemaira®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:

Height/Weight:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Aralast NP® (alpha$_1$-proteinase inhibitor (human)), Glassia® (alpha$_1$-proteinase inhibitor (human)) ☐ Prolastin-C® (alpha$_1$-proteinase inhibitor (human)), ☐ Zemaira® (alpha$_1$-proteinase inhibitor (human))

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Does the member have a diagnosis of alpha-1-antitrypsin (AAT) deficiency?	☐	☐	
2. Is the member 18 years of age or older?	☐	☐	
3. Does the member have a confirmed phenotype of PiZZ, piZ(null), or Pi(null)(null)?	☐	☐	**Please provide documentation**
4. Is the request made by, or in consultation with, a pulmonologist?	☐	☐	**Please provide documentation**
5. Does the member have clinically evident emphysema due to AAT deficiency?	☐	☐	**Please provide documentation**
6. Does documentation show a forced expiratory volume in one second (FEV1) between 30-65% OR a decline in FEV1 > 120 ml in 1 year?	☐	☐	
7. Does the member have a pretreatment serum concentration of AAT < 11µM/L (< 80mg/dL by radial immunodiffusion or 50mg/dL by nephelometry ?	☐	☐	**Please provide documentation**
8. Is the member an active tobacco smoker?	☐	☐	
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does documentation show that the member has responded to treatment, such as elevated AAT levels above baseline and/or	☐	☐	**Please provide documentation**

substantial reduction in lung function deterioration as demonstrated by FEV1 values?			

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.
Additional information:
Physician's Signature:

****Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy PHARM-HCU-002
Origination Date: 01/01/2022
Reviewed/Revised Date: 07/29/2024
Next Review Date: 07/29/2025
Current Effective Date: 08/01/2024

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM

ANKYLOSING SPONDYLITIS

Avsola®, Cimzia®, Cosentyx®, Enbrel®, Hadlima™, Humira®, Inflectra®, infliximab, Remicade®, Renflexis®, Rinvoq®, Simlandi®, Simponi®, Taltz®, Xeljanz/XR®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department.

- For **Medical Pharmacy** please fax requests to: 801-646-7300
- For **Retail Pharmacy** please fax requests to: 385-425-4052

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-formulary drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred/Non-Formulary

1. **1st Line Preferred agents:**
   A. Hadlima™ (adalimumab-bwwd), Simlandi® (adalimumab-ryvk)
   B. Infliximab products: Avsola® (infliximab-axxq), Inflectra® (infliximab-dyyb), infliximab, Remicade (infliximab), Renflexis® (infliximab-abda)
2. **2nd line preferred agents with single step; after trial and failure of BOTH Hadlima or Simlandi, and a preferred infliximab agent:**
   A. Cimzia® (certolizumab), Taltz® (ixekizumab), Xeljanz/XR® (tofacitinib)
3. **Non-Formulary agents with a triple step; after trial and failure of BOTH Hadlima or Simlandi, and a preferred infliximab agent, and 2 second line agents:**
   A. Cosentyx® (secukinumab), Enbrel® (etanercept), Humira® (adalimumab), Rinvoq® (upadacitinib), Simponi® (golimumab)

Product being requested: _____

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Is the member 18 years of age or older with Ankylosing Spondylitis?	☐	☐	**Please provide documentation**
2. Is the requesting provider a rheumatologist or in consultation with one?	☐	☐	
3. Does documentation show an adequate trial and failure of at least one prescription strength nonsteroidal anti-inflammatory	☐	☐	**Please provide documentation**

drug (NSAID) at the maximally tolerated dose, unless contraindicated?			
4. Has the provider performed tuberculosis (TB) screening prior to therapy initiation?	☐	☐	**Please provide documentation**
5. If the request is for a tumor necrosis factor inhibitor, has the provider performed hepatitis B screening prior to therapy initiation?	☐	☐	**Please provide documentation**
6. If the request is for Rinvoq or Xeljanz/XR, does documentation show inadequate response or intolerance to at least one TNF (tumor necrosis factor) blocker such as an infliximab product, Cimzia, an adalimumab product and/or Simponi?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does updated documentation show that the member has a continued medical need?	☐	☐	**Please provide documentation**
3. Does updated documentation show the member responded to therapy, such as a decrease in disease severity or disease stabilization in the Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) or the Ankylosing Spondylitis Disease Activity Score (ASDAS)?	☐	☐	**Please provide documentation**
4. Has the provider performed continued tuberculosis screening during therapy?	☐	☐	**Please provide documentation**
5. Has the provider performed continued Hepatitis B monitoring in HBV carriers?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician's Signature:			

****Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-003
Origination Date: 01/01/2022
Reviewed/Revised Date: 12/24/2024
Next Review Date: 12/24/2025
Current Effective Date: 01/01/2025

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
ANTHELMINTICS
albendazole, Alinia®, Emverm®, nitazoxanide

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Which helminth species is being treated?
Please provide documentation

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred: ☐ albendazole, ☐ Emverm® (mebendazole), ☐ nitazoxanide
Non-preferred: ☐ Alinia® (nitazoxanide) suspension
Non-formulary: Alinia® (nitazoxanide) tablets

Dosing/Frequency:_____

Questions	Yes	No	Comments/Notes
ALBENDAZOLE			
1. Is the medication request for a quantity of #4 per 30 days for treatment of pinworms/roundworm?	☐	☐	**No prior authorization required**
2. For quantities more than #4 per 30 days, is the medication request made by an infectious disease specialist and used for a dose and indication that is FDA-approved, or that is established in the literature?	☐	☐	**Please provide documentation**
EMVERM®			
1. Is the request made by an infectious disease specialist?			
2. Does the member have a diagnosis of ancylostomiasis, ascariasis, enterobiasis, necatoriasis, trichuriasis, capillaria, or cestode?	☐	☐	**Please provide documentation**
3. If the request is to treat pinworm (enterobiasis), does documentation show a trial and failure of over-the-counter pyrantel pamoate, unless contraindicated?	☐	☐	**Please provide documentation**
NITAZOXANIDE			
1. Does the member have a diagnosis of Cryptosporidiosis?	☐	☐	**Please provide documentation**

2. If the member has a diagnosis of giardiasis, does documentation show a trial and failure of metronidazole, unless contraindicated?	☐	☐	**Please provide documentation**
3. If the request is for the treatment of norovirus, is the requesting provider an infectious disease specialist or a transplant provider and is the member immunocompromised?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician's Signature:			

****Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy PHARM-HCU-004
Origination Date: 01/01/2022
Reviewed/Revised Date: 06/11/2025
Next Review Date: 06/11/2026
Current Effective Date: 07/01/2025

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM

Brand Antiemetics for Chemotherapy Induced Nausea and Vomiting

Akynzeo® Capsules,Sancuso® patch, Sustol® subcutaneous injection, Varubi® tablets, Zuplenz®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested:
NK1 antagonist: ☐ Varubi® (rolapitant) tablets
5-HT3 antagonists: ☐Sancuso® (granisetron) patch, ☐ Sustol® (granisetron) SQ injection, ☐ Zuplenz® (ondansetron) film
5-HT3/NK1 combination: ☐ Akynzeo® (netupitant/palonosetron) capsules

Dosing/Frequency:_____

Questions	Yes	No	Comments/Notes
AKYNZEO®			
1. Is this request for prevention of nausea and vomiting associated with moderately to highly emetogenic intravenous chemotherapy regimens?	☐	☐	
2. Has the member tried and failed aprepitant or fosaprepitant in combination with palonosetron?	☐	☐	**Please provide documentation**
SANCUSO®			
1. Is this request for prevention of nausea and vomiting associated with moderately to highly emetogenic intravenous chemotherapy regimens?	☐	☐	
2. Has the member tried and failed all of the following: • ondansetron • granisetron	☐	☐	**Please provide documentation**
SUSTOL®			
1. Is this request for prevention of nausea and vomiting associated with moderately to highly emetogenic intravenous chemotherapy regimens?	☐	☐	
2. Has the member tried and failed all of the following: • Ondansetron • Granisetron	☐	☐	**Please provide documentation**

• Sancuso® patch			
VARUBI®			
1. Is this request for prevention of nausea and vomiting associated with moderately to highly emetogenic intravenous chemotherapy regimens?	☐	☐	
2. Has the member tried and failed aprepitant and fosaprepitant?	☐	☐	**Please provide documentation**
ZUPLENZ®			
1. Is this request for prevention of nausea and vomiting associated with moderately to highly emetogenic intravenous chemotherapy regimens?	☐	☐	
2. Has the member tried and failed all of the following: • Ondansetron ODT • Granisetron	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy PHARM-HCU- 006
Origination Date: 01/01/2022
Reviewed/Revised Date: 08/29/2024
Next Review Date: 08/29/2025
Current Effective Date: 09/01/2024

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
ARANESP®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department.

- For **Medical Pharmacy** please fax requests to: 801-646-7300
- For **Retail Pharmacy** please fax requests to: 385-425-4052

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Aranesp® (darbepoetin alfa)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Is the requesting provider a hematologist, oncologist, nephrologist, or in consultation with one?	☐	☐	
2. Does documentation show that the member's hemoglobin is <10 g/dL and/or that the hematocrit is <30%?	☐	☐	**Please provide documentation**
3. Does the member have one of the following indications: • Anemia of chronic renal failure, • Anemia due to myelosuppressive chemotherapy with a minimum of 8 additional weeks of planned chemotherapy, • Myelodysplasia or myelodysplastic syndrome?	☐	☐	**Please provide documentation**
4. Does the member have one of the following indications: • Request will be used as a substitute for red blood cell transfusion in patients who require immediate correction of anemia, • Uncontrolled hypertension, • Pure Red Cell Aplasia (PRCA) that begins after treatment with erythropoietin drugs?	☐	☐	
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	

2. Has the member responded to treatment, demonstrated by an improvement in the hematocrit and hemoglobin levels or a significant decrease in transfusion requirements?	☐	☐	**Please provide documentation**
3. Is current hemoglobin < 11g/dL OR > 10 to <12 g/dL?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician's Signature:			

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-008
Origination Date: 01/01/2022
Reviewed/Revised Date: 01/29/2025
Next Review Date: 01/29/2026
Current Effective Date: 02/01/2025

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM

BASAL INSULIN

Insulin Glargine, Toujeo®, Insulin Degludec

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred/Non-Preferred

1. **Preferred**
   A. Rezvoglar™ (insulin glargine-aglr); no prior authorization required
2. **Non-Preferred Brands with a single step; after trial and failure of Rezvoglar® and in accordance with Prior Authorization Criteria below**
   A. Insulin Degludec (100 Units/mL and 200 Units/mL)
3. **Non-preferred Brands with a double step; after trial and failure of Rezvoglar® AND Insulin Degludec and in accordance with Prior Authorization Criteria below**
   A. Basaglar® (Insulin glargine 100 Units/mL), Toujeo® (Insulin glargine 300 Units/mL), Insulin glargine 100 Units/ml

Product being requested: _____

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
Insulin Degludec			
1. Does the member have a diagnosis of Type 1 or Type 2 diabetes mellitus or gestational diabetes?	☐	☐	**Please provide documentation**
2. Has the member trialed Basaglar® or Rezvoglar® for at least 3 months?	☐	☐	**Please provide documentation**
Toujeo and Insulin Glargine			
1. Does the member have a diagnosis of Type 1 or Type 2 diabetes mellitus or gestational diabetes?	☐	☐	**Please provide documentation**

2. Has the member trialed Basaglar® or Rezvoglar® and Insulin Degludec for at least 3 months?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member's therapy been re-evaluated within the past 12 months?	☐	☐	
3. Does the member show a continued medical need for the therapy?	☐	☐	**Please provide documentation**
4. Has the therapy been tolerable and effective?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-011
Origination Date: 01/01/2022
Reviewed/Revised Date: 09/18/2024
Next Review Date: 09/18/2025
Current Effective Date: 10/01/2024

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
CYSTIC FIBROSIS TRANSMEMBRANE CONDUCTANCE REGULATOR (CFTR) AGENTS
Kalydeco®, Orkambi®, Symdeko®, Trikafta™

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:

Height/Weight:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Kalydeco® (ivacaftor), ☐ Orkambi® (lumacaftor/ivacaftor), ☐ Symdeko® (tezacaftor/ivacaftor and ivacaftor), ☐ Trikafta™ (elexacaftor/tezacaftor/ivacaftor and ivacaftor)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Does the member have a documented diagnosis of cystic fibrosis (CF) as listed below? • Cystic fibrosis with pulmonary manifestations • Cystic fibrosis with other intestinal manifestations • Cystic fibrosis with other manifestations • Cystic fibrosis, unspecified	☐	☐	**Please provide documentation**
2. Is the requesting provider a cystic fibrosis specialist?	☐	☐	
3. Does the provided documentation show that the member has a CF mutation that the requested medication is indicated to treat?	☐	☐	**Please provide documentation**
4. Does the member have a baseline forced expiratory volume in one second (FEV1) between 40% and 90% of predicted normal value?	☐	☐	**Please provide documentation**
5. Does the member demonstrate at least a 75% history of compliance with the Cystic Fibrosis Center clinic visits over the last 12 months? Documentation of adherence must be provided with the request.	☐	☐	**Please provide documentation**
6. Does the member demonstrate at least 80% adherence to prescribed medication therapies over the last 12 months?	☐	☐	**Please provide documentation**

Adherence to prescribed medications will be verified by claim review and fill history, if available.			
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does the member have a continued medical need for therapy and has the therapy been effective and tolerable?	☐	☐	**Please provide documentation**
3. Has member achieved a clinically significant response to therapy with documentation of at least ONE of the following? • Improvement or stabilization in lung function as demonstrated by a current FEV1 as compared to pre-treatment values. • Improvement or stabilization in Body Mass Index (BMI) as compared to pre-treatment BMI. • Member has a decrease in pulmonary exacerbations as demonstrated by a decrease in hospitalizations, emergency room visits and/or IV antibiotic use.	☐	☐	**Please provide documentation**
4. Is member's ALT or AST not > 5 times the upper limit of normal (UNL) and ALT or AST is not > 3 times the UNL and bilirubin is not > 2 times the UNL?	☐	☐	**Please provide documentation**
5. Is the member followed at least annually by a practitioner who specializes in the care of patients with cystic fibrosis?	☐	☐	
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy PHARM-HCU-014
Origination Date: 01/01/2022
Reviewed/Revised Date: 11/13/2024
Next Review Date: 11/13/2025
Current Effective Date: 12/01/2024

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
CLOSTRIDIUM DIFFICILE DRUGS
Dificid®, Zinplava™

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Dificid® (fidaxomicin), ☐ Zinplava™ (bezlotuxumab)

Dosing/Frequency:_____

Questions	Yes	No	Comments/Notes
DIFICID®			
1. Does the member have a diagnosis of C. difficile based on diarrheal symptoms AND a current positive stool toxin test?	☐	☐	**Please provide documentation**
2. If this is for an initial episode, does documentation show a trial and failure of at least 10 days of oral vancomycin?	☐	☐	**Please provide documentation**
3. If the request is for recurrent C. difficile, does documentation show a trial and failure of pulsed or tapered vancomycin regimen OR a second 10-day course of vancomycin?	☐	☐	**Please provide documentation**
ZINPLAVA™			
1. Is the request for prophylaxis therapy with Zinplava™?	☐	☐	
2. Does the member have a diagnosis of C. difficile based on diarrheal symptoms AND a positive stool toxin test or PCR?	☐	☐	**Please provide documentation**
3. Has the member had at least 2 confirmed recurrent C. difficile episodes (3 total) that have been treated with a vancomycin regimen?	☐	☐	**Please provide documentation**
4. Does documentation show that the second recurrence was treated with pulsed or tapered vancomycin?	☐	☐	**Please provide documentation**
5. Will the member concurrently receive vancomycin or metronidazole?	☐	☐	

6. Is the member at high risk of C. difficile recurrence by meeting one of the following: • Age ≥ 65 years • History of C. difficile infection in the past 6 months • Immunocompromised state • C. diff ribotype 027 • Severe C. difficile infection at presentation with white blood cell ≥15,000 cells/mm^3 OR serum creatinine > 1.5g/dL	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of Dificid®?	☐	☐	
2. Does updated documentation show continued medical need and tolerance of therapy?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:

Physician Signature:

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy PHARM-HCU-015
Origination Date: 01/01/2022
Reviewed/Revised Date: 12/30/2024
Next Review Date: 12/30/2025
Current Effective Date: 01/01/2025

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM

Calcitonin Gene-Related Peptide (CGRP) Receptor Antagonists for Migraine Prevention

Aimovig®, Ajovy®, Emaglity®, Nurtec®, Qulipta™

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:

Height/Weight:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred: ☐ Ajovy® (fremanezumab-vfrm), ☐ Emgality® (galcanezumab-gnlm)
Non-preferred: ☐ Aimovig® (erenumab-aooe), ☐ Nurtec® (rimegepant) ☐ Qulipta™ (atogepant)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
EPISODIC MIGRAINE, CHRONIC MIGRAINE			
1. Does the member have a diagnosis of episodic or chronic migraines?	☐	☐	**Please provide documentation**
2. Has the member had at least a **3-month trial and failure of a beta-blocker** (propranolol, metoprolol, etc.) and **at least 1** of the following: • Calcium channel blocker (verapamil, nifedipine, etc.) • Antidepressant (amitriptyline, venlafaxine, etc.) • Anticonvulsant (topiramate, gabapentin, divalproex, etc.) • Angiotensin converting enzyme (ACE) inhibitor (Lisinopril, etc.), OR **If a beta-blocker cannot be tried, does documentation show a trial and failure of at least 2 of the agents listed above?**	☐	☐	**Please provide documentation**
3. Is the member taking a Calcitonin Gene-Related Peptide (CGRP) medication or Reyvow (lasmiditan) to treat migraine headaches?	☐	☐	**Please provide documentation**
4. If the request is for Aimovig® (erenumab-aooe) for migraine prevention, has the member tried and failed, or have a contraindication to, ALL of the following?	☐	☐	**Please provide documentation**

• Ajovy®(Fremanezumab-vfrm) • Emgality®(galcanezumab-gnlm)			
5. If the member is requesting Qulipta™ (atogepant) for migraine prevention, does the member have a physical or mental disability that makes an injection not possible OR has the member tried and failed, or have a contraindication to, ALL of the following? • Ajovy®(Fremanezumab-vfrm) • Emgality®(galcanezumab-gnlm) • Aimvog®(erenumab-aooe)	☐	☐	**Please provide documentation**
6. If the request is for Nurtec® (rimegepant) for migraine prevention, has the member tried and failed, or have a contraindication to, ALL of the following? • Ajovy®(Fremanezumab-vfrm) • Emgality®(galcanezumab-gnlm) • Aimvog®(erenumab-aooe) • Qulipta®(atogepant)	☐	☐	**Please provide documentation**
CLUSTER HEADACHE			
1. If the request is for Emgality® (galcanezumab) to treat cluster headache, does documentation show at least 2 cluster periods with at least 5 attacks lasting 7-days to 1 year (when untreated) and separated by pain-free remission periods of 3 months or more?	☐	☐	**Please provide documentation**
2. Has the member had at least a 3-month trial and failure or contraindication/intolerance of verapamil titrated up to the maximum tolerated FDA-approved dose?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does documentation show the member had a positive response to therapy?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			

Physician Signature:

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-016
Origination Date: 01/01/2022
Reviewed/Revised Date: 05/27/2025
Next Review Date: 05/27/2026
Current Effective Date: 06/01/2025

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
CONSTIPATION MEDICATIONS

Amitiza®, Linzess®, Motegrity™, Movantik®, Relistor®, Symproic®, Trulance®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:

Height/Weight:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred: ☐ Linzess® (linaclotide), ☐ lubiprostone*, ☐ Movantik® (naloxegol)
Non-preferred: ☐ prucalopride, ☐ Symproic® (naldemedine), ☐ Trulance® (plecanatide)
Non-formulary: ☐ Relistor® (methylnaltrexone)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
CHRONIC IDIOPATHIC CONSTIPATION			
1. Has the member been diagnosed with Chronic Idiopathic Constipation?	☐	☐	
2. Has the member had a trial and failure of a laxative such as lactulose or polyethylene glycol?	☐	☐	**Please provide documentation**
3. If the request for Linzess®, has the member had an adequate trial and failure of lubiprostone?	☐	☐	**Please provide documentation**
4. If the request is for prucalopride or Trulance®, has the member had an adequate trial and failure of Linzess® and lubiprostone?	☐	☐	**Please provide documentation**
IRRITABLE BOWEL SYNDROME WITH CONSTIPATION			
1. Has the member been diagnosed with Irritable Bowel Syndrome with constipation?	☐	☐	
2. Has the member had a trial and failure of a laxative such as lactulose or polyethylene glycol?	☐	☐	**Please provide documentation**
3. If the request is for Linzess®, has the member had an adequate trial and failure of lubiprostone?	☐	☐	**Please provide documentation**

4. If the request is for prucalopride or Trulance®, has the member had an adequate trial and failure of Linzess® and lubiprostone?	☐	☐	**Please provide documentation**
OPIOID INDUCED CONSTIPATION			
1. Has the member been diagnosed with opioid induced constipation?	☐	☐	
2. Has the member had a trial and failure of a laxative such as lactulose or polyethylene glycol?	☐	☐	**Please provide documentation**
3. If the request for Movantik®, has the member had an adequate trial and failure of lubiprostone?	☐	☐	**Please provide documentation**
4. If the request is for Symproic®, has the member had an adequate trial and failure of Movantik® and lubiprostone?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member's therapy been re-evaluated within the past 12 months?	☐	☐	
3. Has the therapy shown to be effective with an improvement in the member's condition?	☐	☐	**Please provide documentation**
4. Does the member show a continued medical need for the therapy?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:

Physician Signature:

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-017
Origination Date: 01/01/2022
Reviewed/Revised Date: 04/09/2025
Next Review Date: 04/09/2026
Current Effective Date: 05/01/2025

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
CROHN'S DISEASE MEDICATIONS

Avsola®, Cimzia®, Entyvio®, Hadlima™, Humira®, Inflectra®, infliximab, Omvoh®, Remicade®, Renflexis®, Rinvoq®, Simlandi®, Skyrizi®, Stelara®, Tremfya®, Yesintek™

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department.

- For **Medical Pharmacy** please fax requests to: 801-646-7300
- For **Retail Pharmacy** please fax requests to: 385-425-4052

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred/Non-Formulary:

1. **1st Line Preferred Agents:**
   - A. Hadlima™ (adalimumab-bwwd), Simlandi® (adalimumab-ryvk)
   - B. Infliximab products: Avsola® (infliximab-axxq), Inflectra® (infliximab-dyyb), infliximab, Remicade (infliximab), Renflexis® (infliximab-abda)
   - C. Yesintek™ (ustekinumab-kfce)
2. **2nd line preferred agents with single step; after trial and failure of an adalimumab product, an ustekinumab product and an infliximab product:**
   - a. Cimzia® (certolizumab), Entyvio® (vedolizumab) IV
3. **Non-Formulary agents with a triple step; after trial and failure of an adalimumab product, an ustekinumab product, an infliximab product and Entyvio IV:**
   - A. Rinvoq® (upadacitinib)
4. **Non-Formulary Agent after trial and failure of all the above:**
   - a. Entyvio® (vedolizumab) subcutaneous injection, Omvoh® (mirikizumab-mrkz), Skyrizi® (risankizumab-rzaa), Tremfya® (guselkumab)

Product being requested: _____

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Is the request being made by or in consultation with a gastroenterologist?	☐	☐	
2. Does documentation include results from studies such as colonoscopy, MRI, CT scan?	☐	☐	**Please provide documentation**

3. Does the member have severe Crohn's Disease evidenced by at least one of the following: • A Crohn's Disease Activity Score (CDAI) >220 AND as shown on imaging • Active fistulizing disease	☐	☐	**Please provide documentation**
4. Does the member have moderate to severe Crohn's Disease evidenced by the following: • Persistent fistulizing disease or active ulcerative disease as shown on imaging and via CDAI > 150 despite an adequate trial with an immunomodulating medication such as methotrexate, azathioprine or 6-mercaptopurine, unless contraindicated to all.	☐	☐	**Please provide documentation**
5. Has the provider performed tuberculosis (TB) screening prior to therapy initiation?	☐	☐	**Please provide documentation**
6. If the request is for a Tumor Necrosis Factor Inhibitor, has the provider performed hepatitis B screening prior to therapy initiation?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does documentation show a stabilization or decrease in the CDAI score of at least 70 points compared to baseline, endoscopic improvement in mucosa and/or no new fistulizing disease information?	☐	☐	**Please provide documentation**
3. Has the provider performed continued tuberculosis monitoring during therapy?	☐	☐	**Please provide documentation**
4. Has the provider performed continued Hepatitis B monitoring in HBV carriers?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

****Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-019
Origination Date: 01/01/2022
Reviewed/Revised Date: 05/27/2025
Next Review Date: 05/27/2026
Current Effective Date: 0/01/2025

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
DUPIXENT® for ASTHMA and EOSINOPHILIC ESOPHAGITIS (EoE) and PRURIGO NODULARIS

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Dupixent® (dupilumab)

Dosing/Frequency:_____

Note: for the treatment of nasal polyps see Chronic Rhinosinusitis with Nasal Polyposis (CRSwNP); for the treatment of atopic dermatitis see Brand Name Atopic Dermatitis Agents

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
ASTHMA			
1. Does the member have a diagnosis of moderate to severe asthma?	☐	☐	**Please provide documentation**
2. Is the request made by, or in consultation with, an allergist, pulmonologist or immunologist?	☐	☐	
3. Has the member had a trial and failure of Fasenra® (benralizumab), unless contraindicated?	☐	☐	**Please provide documentation**
4. Has the member been compliant for at least 5 months with high dose inhaled corticosteroid/long-acting inhaled beta-2 agonist or with high-dose inhaled corticosteroid/leukotriene receptor antagonist?	☐	☐	**Please provide documentation**
5. Does the member have poor asthma control with recurrent exacerbations that have required emergency department visits, hospitalizations, or frequent office visits?	☐	☐	**Please provide documentation**
6. Does documentation show that the member's FEV1 is less than 80%?	☐	☐	**Please provide documentation**
7. Are underlying conditions or triggers for asthma or pulmonary disease being maximally managed (i.e. inhaled respiratory irritants – tobacco, allergen exposure, physical activity,	☐	☐	**Please provide documentation**

medications, emotional factors, respiratory infections, COPD, etc.)?			
8. Does the member have a baseline eosinophil count ≥ 300 cells/µL in the last 6 weeks?	☐	☐	**Please provide documentation**
9. Has the member required daily oral corticosteroid therapy for at least the last 6 months?			
EOSINOPHILIC ESOPHAGITIS (EoE)			
1. Does the member have a confirmed diagnosis of EoE with 15 or more intraepithelial eosinophils per high-power field (eos/hpf) from esophageal biopsy and have symptoms of dysphagia?	☐	☐	**Please provide documentation**
2. Is the request made by, or in consultation with, an allergist, or a gastroenterologist?	☐	☐	
3. Has the member had a trial and failure of the following: • Diet modification • Proton-Pump Inhibitor • Topical glucocorticosteroid treatment	☐	☐	**Please provide documentation**
4. Does the member weigh more than 40kg?	☐	☐	**Please provide documentation**
PRURIGO NODULARIS (PN)			
1. Is the request made by a provider specializing in dermatology, allergy, or immunology?	☐	☐	
2. Is the disease involvement rated as moderate to severe?	☐	☐	**Please provide documentation**
3. Has the member tried phototherapy?	☐	☐	**Please provide documentation**
4. Has the member had an adequate trial with at least two moderate to very high potency prescription corticosteroids?	☐	☐	**Please provide documentation**
5. If unable to tolerate corticosteroids due to the treatment area (e.g. face, genitals, etc.), has the member had an adequate trial with a calcineurin inhibitor such as topical tacrolimus?	☐	☐	**Please provide documentation**
6. Has the member tried cyclosporine or methotrexate within the past 6 months?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
ASTHMA			
1. Is the request for reauthorization for asthma therapy?	☐	☐	
2. Is there evidence of positive clinical response as defined by documentation demonstrating reduced hospitalization and/or emergency room visits?	☐	☐	**Please provide documentation**
EOSINOPHILIC ESOPHAGITIS (EoE)			
1. Is the request for reauthorization of chronic EoE therapy?	☐	☐	
2. Is there evidence of positive clinical response as defined by documentation demonstrating improvement in eos/hpf from baseline and symptoms?	☐	☐	**Please provide documentation**
PRURIGO NODULARIS (PN)			
1. Is the request for reauthorization of prurigo nodularis therapy?	☐	☐	
2. Is there evidence of a positive clinical response to therapy?			**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			

Additional information:
Physician Signature:

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-022
Origination Date: 01/01/2022
Reviewed/Revised Date: 04/09/2025
Next Review Date: 04/09/2026
Current Effective Date: 05/01/2025

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
GONADOTROPIN RELEASE HORMONE AGONISTS AND ANTAGONISTS
Eligard®, Lupron Depot®, Lupron Depot- Ped®, Orilissa®,
Supprelin® LA, Zoladex®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department.

- For **Medical Pharmacy** please fax requests to: 801-646-7300
- For **Retail Pharmacy** please fax requests to: 385-425-4052

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred product is dependent on indication - see below.
Requested Agent: ☐ Eligard® (leuprolide acetate), ☐ Lupron Depot® (leuprolide acetate), ☐ Lupron Depot- Ped® (leuprolide acetate), ☐ Zoladex® (goserelin), ☐ Orilissa (elagolix) 200 mg
Non-Preferred Agents: ☐ Supprelin® LA (histrelin), ☐ Orilissa (elagolix) 150 mg

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
ADVANCED BREAST CANCER			
1. Does the member have a diagnosis of advanced breast cancer?	☐	☐	**Please provide documentation**
2. Is the member ≥18 years of age?	☐	☐	
3. Is the prescriber an oncologist or endocrinologist?	☐	☐	
4. Is the request for the preferred product Zoladex®?	☐	☐	
CENTRAL PRECOCIOUS PUBERTY			
1. Does the member have a diagnosis of central precocious puberty?	☐	☐	
2. Is the prescriber a pediatric endocrinologist?	☐	☐	
3. Does documentation show baseline LH levels and a LH concentration after GnRH stimulation test?	☐	☐	**Please provide documentation**
4. Does documentation show a baseline LH/FSH ratio and a LH/FSH ratio after GnRH stimulation test ?	☐	☐	**Please provide documentation**

5. Does documentation show the member's baseline bone age is 1 year greater than chronological age?	☐	☐	**Please provide documentation**
6. Does documentation include the member's age at onset of secondary sexual characteristics?	☐	☐	**Please provide documentation**
7. Does documentation show the member's Tanner Stage is ≥ 2?	☐	☐	**Please provide documentation**
8. Have the following diagnoses been ruled out? • Adrenal steroid levels for congenital adrenal hyperplasia • Beta human chorionic gonadotropin level for chorionic gonadotropin secreting tumor • Pelvic/adrenal/testicular ultrasound for steroid secreting tumor • CT scan of head to rule out intracranial tumor	☐	☐	**Please provide documentation**
9. Is the request for the preferred product Lupron Depot-Ped® or Vantas®?	☐	☐	
ENDOMETRIOSIS			
1. For endometriosis with inadequate pain control, is the request for the preferred product Lupron Depot® or Zoladex®? **Imaging confirming the diagnosis is required.**	☐	☐	**Please provide documentation**
2. For endometriosis with inadequate pain control, if the request is for Orilissa® 150 mg, has the member tried and failed Lupron Depot® and Zoladex®? 3. **Imaging confirming the diagnosis is required.**	☐	☐	**Please provide documentation**
4. For endometriosis with dyspareunia and inadequate pain control, is the request for Orilissa® 200 mg? 5. **Imaging confirming the diagnosis is required.**	☐	☐	**Please provide documentation**
6. Is the requesting provider an OB/GYN?	☐	☐	
7. Does documentation show a negative pregnancy test?	☐	☐	**Please provide documentation**
8. Has the member tried and failed at least two of the following: • A combination (estrogen-progesterone) contraceptive taken continuously • A progestin such as DepoProvera® (medroxyprogesterone), Nexplanon® (etonogestrel) or Mirena® (levonorgestrel) • Danazol	☐	☐	**Please provide documentation**
ENDOMETRIAL THINNING			
1. Is the member ≥18 years of age?	☐	☐	
2. Is the requesting provider an OB/GYN?	☐	☐	
3. Is the requested therapy for dysfunctional uterine bleeding prior to endometrial ablation?	☐	☐	**Please provide documentation**
4. Is the request for the preferred product Zoladex®?	☐	☐	
PROSTATE CANCER			
1. Is the member ≥ 18 years of age?	☐	☐	
2. Is the requesting prescriber an oncologist or endocrinologist?	☐	☐	
3. Is the request for the preferred product Eligard®?	☐	☐	

UTERINE LEIOMYOMATA			
1. Is the request for the preferred product Lupron Depot®?	☐	☐	**If yes, please complete questions 2 to 4**
2. Is the member ≥ 18 years of age?	☐	☐	
3. Does the member have a diagnosis of uterine leiomyomata requiring option of surgical intervention?	☐	☐	**Please provide documentation**
4. Does documentation show a clinical estimation of the size of uterus or fibroids?	☐	☐	**Please provide documentation**
5. Is the request for Oriahnn®?	☐	☐	**If yes, complete questions 6 to 11**
6. Is the prescribing provider an OB/GYN, or in consultation with one?	☐	☐	
7. Has the member tried and failed Lupron Depot® AND at least one of the following therapies unless contraindicated? • Combined estrogen-progestin contraceptive • Levonorgestrel-releasing intrauterine systems • Tranexamic acid	☐	☐	**Please provide documentation**
8. Does the member have a clinical diagnosis of uterine leiomyomata (fibroid) as shown by ultrasound?	☐	☐	**Please provide documentation**
9. Does the member have a negative pregnancy test?	☐	☐	**Please provide documentation**
10. Has an endometrial biopsy been performed to rule out endometrial cancer?	☐	☐	**Please provide documentation**
11. Does the member have a t-score > -2.0 at the lumbar spine, total hip, and femoral neck?	☐	☐	**Please provide documentation**
ADOLESCENT GENDER DYSPHORIA			
1. See PHARM-HCU-150 Hormone Therapy for Gender Dysphoria.	☐	☐	
REAUTHORIZATION			
Breast Cancer			
1. Does the member have a continued medical need for therapy?	☐	☐	**Please provide documentation**
2. Has the therapy been effective and tolerable?	☐	☐	**Please provide documentation**
CENTRAL PRECOCIOUS PUBERTY			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does documentation show suppression of increasing LH and FSH levels from baseline?	☐	☐	**Please provide documentation**
3. Has the member's height velocity slowed or stabilized from baseline?	☐	☐	**Please provide documentation**
4. Has the member's bone age slowed from baseline?	☐	☐	**Please provide documentation**
5. Is there a stabilization or regression of the member's Tanner Staging?	☐	☐	**Please provide documentation**
6. Is the member ≤12 years of age if female or ≤13 years of age if male?	☐	☐	
ENDOMETRIOSIS			
1. Does the member have a recurrence of symptoms?	☐	☐	**Please provide documentation**
2. Is the request for Lupron Depot® (leuprolide) or Zoladex® (goserelin) AND has the member received < 12 months of therapy?	☐	☐	**Please provide documentation**

PROSTATE CANCER			
1. Does the member have a continued medical need for therapy?	☐	☐	**Please provide documentation**
2. Has the therapy been effective and tolerable?	☐	☐	**Please provide documentation**
UTERINE LEIOMYOMATA			
1. Does the member have a continued medical need for therapy?	☐	☐	**Please provide documentation**
2. Is the request for Oriahnn® AND has the member received < 24 months of therapy months of therapy?	☐	☐	**Please provide documentation**
ADOLESCENT GENDER DYSPHORIA			
1. See PHARM-HCU-150 Hormone Therapy for Gender Dysphoria for reauthorization.	☐	☐	
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy PHARM-HCU-026
Origination Date: 01/01/2022
Reviewed/Revised Date: 01/29/2025
Next Review Date: 01/29/2026
Current Effective Date: 02/01/2025

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
GROWTH HORMONE-ADULT

Genotropin®, Humatrope®, Norditropin®, Nutropin AQ®, Omnitrope® Saizen®, Serostim®, Zomacton®, Zorbtive®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred: ☐ Norditropin® (somatropin)
Non-Formulary: ☐ Genotropin® (somatropin), ☐ Humatrope® (somatropin), ☐ Nutropin AQ® (somatropin), ☐ Omnitrope® (somatropin) ☐ Saizen® (somatropin), ☐ Serostim® (somatropin), ☐ Skytropha® (lonapegsomatropin) ☐ Zomacton® (somatropin), ☐ Zorbtive® (somatropin)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
GROWTH HORMONE DEFICIENCY IN ADULTS			
1. Does the member have the diagnosis of growth hormone deficiency in adults?	☐	☐	
2. Is the ordering provider an endocrinologist?	☐	☐	
3. Does the member have a pituitary hormone deficiency (other than growth hormone) requiring hormone replacement therapy?	☐	☐	**Please provide documentation**
4. Does the member have a pituitary disease or a condition affecting the pituitary (e.g. pituitary tumor, surgical damage, hypothalamic disease, irradiation, trauma, panhypopituitarism, or infiltrative disease)?	☐	☐	**Please provide documentation**
5. Has the member had a growth hormone provocative stimulation test with a measured peak level of <5 ng/mL?	☐	☐	**Please provide documentation**
6. Does the member have 3 pituitary hormone deficiencies (other than growth hormone) that require replacement therapy AND have an insulin-like growth factor (IGF-1) <80 ng/mL?	☐	☐	**Please provide documentation**

SHORT BOWEL SYNDROME			
1. Does the member have the diagnosis of Short Bowel Syndrome?	☐	☐	
2. Is the provider a gastroenterologist?	☐	☐	
3. Is the member able to ingest solid food?	☐	☐	
4. Is the member receiving parenteral nutrition at least 5 days/week to provide at least 3,000 calories per week?	☐	☐	
5. Has the member met with a nutritionist and documentation indicates that dietary needs and goals have been discussed?	☐	☐	**Please provide documentation**
ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)			
1. Does the member have the diagnosis of Acquired Immune Deficiency Syndrome (AIDS) Wasting Syndrome in adults?	☐	☐	
2. Is the requesting provider an infectious disease specialist?	☐	☐	
3. Is the member currently take antiretroviral medications?	☐	☐	**Please provide documentation**
4. Does the member have a documented weight loss of at least 10% from baseline weight OR a body mass index (BMI) of <20?	☐	☐	**Please provide documentation**
5. Has the member had an adequate nutritional evaluation and has failed to respond to a high calorie intake diet?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does updated documentation show continued medical necessity and clinical efficacy?	☐	☐	**Please provide documentation**
3. For a diagnosis of AIDS, has the member demonstrated weight gain within the initial 12 weeks of therapy?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-027
Origination Date: 01/01/2022
Reviewed/Revised Date: 11/13/2024
Next Review Date: 11/13/2025
Current Effective Date: 12/01/2024

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
GROWTH HORMONE-CHILD

Genotropin®, Humatrope®, Norditropin®, Nutropin AQ®, Omnitrope®, Saizen®, Serostim®, Skytrofa®, Zomacton®, Zorbtive®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred: ☐ Norditropin® (somatropin)
Non-Formulary: ☐ Genotropin® (somatropin), ☐ Humatrope® (somatropin), ☐ Nutropin AQ® (somatropin), ☐ Omnitrope® (somatropin) ☐ Saizen® (somatropin), ☐ Serostim® (somatropin), ☐ Skytropha® (lonapegsomatropin) ☐ Zomacton® (somatropin), ☐ Zorbtive® (somatropin)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
GROWTH HORMONE DEFICIENCY (GHD)			
1. Does the member have the diagnosis of GHD in children?	☐	☐	
2. Is the requesting provider a pediatric endocrinologist?	☐	☐	
3. Has the member had TWO separate growth hormone stimulation tests with levels less than 10ng/mL? • One GH stimulation test below 10 ng/ml (microgram/L) is sufficient for children with defined central nervous system (CNS) pathology, history of irradiation, or genetic conditions associated with GHD.	☐	☐	**Please provide documentation**
4. Has the member had ONE growth hormone stimulation test with peak level less than 15 ng/mL, and ONE IGF-I (insulin-like growth factor) and IGF-BP3 (insulin-like growth factor binding protein 3) level below normal for the member's bone age and gender?	☐	☐	**Please provide documentation**
5. Does the member have two or more other pituitary hormone deficiencies in addition to GHD?	☐	☐	**Please provide documentation**

• GH stimulation tests, IGF-1 or IGF-BP3 levels are not needed if multiple pituitary hormone deficiencies exist.			
6. Does the member have congenital GHD? • GH stimulation tests, IGF-1 or IGF-BP3 levels are not needed for GHD if multiple pituitary hormone deficiencies exist.	☐	☐	**Please provide documentation**
7. Does the member have documentation of short stature/growth failure?	☐	☐	**Please provide documentation**
8. Is the member height below the 3rd percentile for the member's age and gender?	☐	☐	**Please provide documentation**
9. Does the member have an untreated growth velocity below the 25th percentile AND a height below the 5th percentile for the members age and gender?	☐	☐	**Please provide documentation**
10. Does the member have open growth plates?	☐	☐	**Please provide initial bone age**
PRADER-WILLI SYNDROME (PWS)			
1. Does the member have the diagnosis of PWS?	☐	☐	
2. Is the requesting provider a pediatric endocrinologist?	☐	☐	
3. Has the diagnosis of PWS been confirmed with genetic testing?	☐	☐	**Please provide documentation**
4. Is the member severely obese, have a history of upper airway obstruction or sleep apnea, or have a severe respiratory impairment?	☐	☐	**Please provide documentation**
SMALL GESTATIONAL AGE			
1. Is the request for growth failure in children who fail to demonstrate catch-up growth by age 2 to 4 years?	☐	☐	
2. Is the requesting provider a pediatric endocrinologist?	☐	☐	
3. Does documentation show that the member was born small for gestational age, defined as a birth weight and/or length of 2 or more standard deviations below the mean?	☐	☐	**Please provide documentation**
4. Does documentation show short stature/growth failure by 2 years of age when height is 2 or more standard deviations below the mean for member's age and gender?	☐	☐	**Please provide documentation**
5. Have other causes for short stature such as growth inhibiting medication, endocrine disorders, and emotional deprivation or syndromes been ruled out?	☐	☐	
6. Does the member have open growth plates?	☐	☐	**Please provide initial bone age**
7. Is the member 2 years of age or older?	☐	☐	
TURNER'S OR NOONAN'S SYNDROME			
1. Is the request for growth failure associated with Turner's or Noonan's Syndrome?	☐	☐	
2. Is the requesting provider a pediatric endocrinologist?	☐	☐	
3. Does the member have open growth plates?	☐	☐	**Please provide initial bone age**
4. Does documentation show subnormal growth rate when height is below the 10th percentile for the member's age and gender?	☐	☐	**Please provide documentation**
SHORT STATURE HOMEOBOX-CONTAINING GENE (SHOX) DEFICIENCY			
1. Is the request for short stature or growth failure in children with short stature homeobox-containing gene (SHOX) deficiency?	☐	☐	
2. Is the requesting provider a pediatric endocrinologist?	☐	☐	

3. Does documentation show subnormal growth rate when height is at least 2 standard deviations below the normal mean for member's age and gender?	☐	☐	**Please provide documentation**
4. Does the member have open growth plates?	☐	☐	**Please provide initial bone age**
CHRONIC RENAL INSUFFICIENCY			
1. Is the request for growth failure associated with chronic renal insufficiency?	☐	☐	
2. Is the requesting provider a pediatric nephrologist?	☐	☐	
3. Does documentation show subnormal growth rate when height is below the 5th percentile and untreated growth velocity with a minimum of 1 year of growth data is below the 25th percentile for member's age and gender?	☐	☐	**Please provide documentation**
4. Does the member require weekly dialysis or have a glomerular filtration rate (GFR) <75 ml/min/1.73 m^2?	☐	☐	**Please provide documentation**
5. Does the member have open growth plates?	☐	☐	**Please provide initial bone age**
PEDIATRIC BURNS			
1. Is the request for a pediatric member with burns ≥ 40% of the total body surface area?	☐	☐	**Please provide documentation**
2. Is the requesting provider a trauma/burn surgeon?	☐	☐	
NON-GROWTH HORMONE DEFICIENT SHORT STATURE (IDIOPATHIC SHORT STATURE)			
1. Is the pediatric member 5 years of age or older?	☐	☐	
2. Does documentation show pediatric member's height is less than 1.2 percentile or a standard deviation score (SDS) < -2.25 for pediatric member's age and gender?	☐	☐	**Please provide documentation**
3. Does documentation show that the member has a growth rate of < 4 cm per year OR growth (height) velocity is < 10th percentile for the member's age and gender based on at least 6 months of growth data?	☐	☐	**Please provide documentation**
4. Is the member's predicted adult height < 160 cm (63 inches) in males or < 150 cm (59 inches) in females) without growth hormone therapy?	☐	☐	**Please provide documentation**
5. Are the epiphyses open?	☐	☐	
6. Does the member have constitutional delay of growth and puberty (CDGP)?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy? **Note: For pediatric burns a maximum of 12 months of therapy may be allowed.**	☐	☐	
2. Has the member's growth velocity been ≥2.5 cm/year?	☐	☐	**Please provide documentation**
3. Is the member's bone age ≤16 in males or ≤14 in females?	☐	☐	**Please provide documentation**
4. For chronic renal insufficiency, does the member require weekly dialysis or have a glomerular filtration rate (GFR) <75 mL/min/1.73 m^2?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			

Additional information:
Physician Signature:

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-028
Origination Date: 01/01/2022
Reviewed/Revised Date: 11/13/2024
Next Review Date: 11/13/2025
Current Effective Date: 12/01/2024

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PRIOR AUTHORIZATION REQUEST FORM
HEPATITIS C DIRECT ACTING ANTIVIRALS

ledipasvir/sofosbuvir, sofosbuvir/velpatasvir, Mavyret®, Sovaldi®, Viekira Pak®, Vosevi®, Zepatier®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred: ☐ ledipasvir/sofosbuvir (Harvoni® authorized generic), ☐ sofosbuvir/velpatasvir (Epclusa® authorized generic), ☐ Mavyret® (glecaprevir/pibrentasvir)
Non-Formulary: ☐ Sovaldi® (sofosbuvir), ☐ Viekira Pak® (ombitasvir/paritaprevir/ritonavir and dasabuvir), ☐ Vosevi® (sofosbuvir/velpatasvir/voxilaprevir), ☐ Zepatier® (elbasvir/grazoprevir)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
For use in Hepatitis C Virus (HCV) infection			
1. Is the requesting prescriber a gastroenterologist, hepatologist, transplant specialist, infectious disease specialist, or a provider registered with Project ECHO-HCV (Extension for Community Healthcare Outcomes)?	☐	☐	
2. Does the member have a documented diagnosis of chronic HCV infection with documentation of a positive qualitative HCV RNA test?	☐	☐	**Please provide documentation**
3. Does documentation include a quantitative viral load?	☐	☐	**Please provide documentation**
4. Has the member's HCV genotype been obtained? • Not required for Sofosbuvir/velpatasvir (Epclusa® authorized generic)	☐	☐	**Please provide documentation**
5. Does the member have current issues with compliance?	☐	☐	
6. Does documentation include a complete medication list?	☐	☐	**Please provide documentation**
7. If the request is for Mavyret, does the member have moderate or severe impairment (Child-Pugh class B or C)?	☐	☐	**Please provide documentation**

For use in retreatment of Hepatitis C Virus (HCV) infection			
1. Is the requesting prescriber a gastroenterologist, hepatologist, transplant specialist, infectious disease specialist, or a provider registered with Project ECHO-HCV (Extension for Community Healthcare Outcomes)?	☐	☐	
2. Does the member have a documented diagnosis of chronic HCV infection with documentation of a positive qualitative HCV RNA test?	☐	☐	**Please provide documentation**
3. Does documentation include a quantitative viral load?	☐	☐	**Please provide documentation**
4. If the member had a sofosbuvir-based treatment failures, is the request for the preferred agent Mavyret?	☐	☐	**Please provide documentation**
5. If the member had a Mavyret treatment failure, is the request for Vosevi?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician's Signature:			

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-030
Origination Date: 01/01/2022
Reviewed/Revised Date: 11/13/2024
Next Review Date: 11/13/2025
Current Effective Date: 12/01/2024

HEALTH | CHOICE
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PRIOR AUTHORIZATION REQUEST FORM
HEREDITARY ANGIOEDEMA AGENTS

Berinert®, Cinryze®, icatibant, Firazyr®, Haegarda®, Kalbitor®, Takhzyro®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred: ☐ Berinert®(C1 esterase inhibitor [human])*, ☐ Haegarda® (C1 esterase inhibitor [human]), ☐ icatibant
Non-preferred: : ☐ Cinryze® (C1 esterase inhibitor subcutaneous [human]) ☐ Firazyr® (icatibant), ☐ Kalbitor® (ecallantide), ☐ Takhzyro® (lanadelumab)

*preferred for specified populations. Refer to medication use policy.

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Is the request for treatment of Hereditary Angioedema (HAE)?	☐	☐	
2. Is the requesting provider a board-certified immunologist or allergist?	☐	☐	
3. Does the member have clinical presentations consistent with a HAE subtype (HAE I, HAE II, or HAE with normal C1INH) confirmed by repeat blood testing?	☐	☐	**Please provide documentation**
4. Has the member's diagnosis of Hereditary Angioedema been confirmed with complement 4 (C4) protein and C1-inhibitor levels?	☐	☐	**Please provide documentation**
5. Has the member had a trial and failure of each of the following: antihistamines, glucocorticoids, and epinephrine?	☐	☐	**Please provide documentation**
6. Is the member currently taking ACE-inhibitors or estrogen-containing oral medications?	☐	☐	
7. Has the member's attack frequency, severity, and location been documented?	☐	☐	**Please provide documentation**
8. Is the member/caregiver able and ready to administer medication at home?	☐	☐	

9. For acute HAE attack treatment: Does the member have a history of at least one attack per year?	☐	☐	**Please provide documentation**
10. For long-term prophylaxis of HAE attacks: Does the member have a history of two acute severe attacks per month or at least 5 attacks of moderate severity per month on average?	☐	☐	**Please provide documentation**
11. For long-term prophylaxis of HAE attacks: Has the member tried and failed, or have a contraindication to, danazol therapy?	☐	☐	**Please provide documentation**
12. For long-term prophylaxis of HAE attacks: Does laboratory test show the member has not experienced HAE attacks due to preventable triggers, such as helicobacter pylori infections in members with gastrointestinal attacks?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member experienced unacceptable toxicity (e.g. hypersensitivity reactions, serious thrombotic events, significantly elevated hepatic serum transaminases) to the drug?	☐	☐	
3. For acute HAE attack treatment: Does documentation show that the member continues to experience at least one acute HAE attack per year AND is the request for a refill due to a documented attack OR has the medication on hand reached the expiration date?	☐	☐	**Please provide documentation**
4. For long-term prophylaxis of HAE attacks: Has the provider evaluated the member's need for long-term prophylaxis at least once per year?	☐	☐	
5. For long-term prophylaxis of HAE attacks: Has the member had significant improvements in severity and duration of attacks compared to baseline?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician's Signature:			

****Failure to submit clinical documentation to support this request will result in a dismissal of the request****

Policy PHARM-HCU-031
Origination Date: 01/01/2022
Reviewed/Revised Date: 11/13/2024
Next Review Date: 11/13/2024
Current Effective Date: 12/01/2024

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
HIDRADENITIS SUPPURATIVA
Avsola®, Bimzelx®, Cosentyx®, Hadlima™, Humira®, Inflectra®, infliximab, Renflexis®, Remicade®, Simlandi®, Yesintek™

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department.

- For **Medical Pharmacy** please fax requests to: 801-646-7300
- For **Retail Pharmacy** please fax requests to: 385-425-4052

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred/Non-Preferred:

1. **1st Line Preferred Agents:**
   - A. Adalimumab products: Hadlima™ (adalimumab-bwwd), Simlandi® (adalimumab-ryvk)
   - B. Infliximab products: Avsola® (infliximab-axxq), Inflectra® (infliximab-dyyb), infliximab, Remicade® (infliximab), Renflexis® (infliximab-abda)
   - C. Ustekinumab products: Yesintek™ (ustekinumab-kfce)
2. **Non-Formulary; after trial and failure of an adalimumab product, an infliximab product AND an ustekinumab product:**
   - A. Cosentyx® (secukinumab)
3. **Non-Formulary; after trial and failure of an adalimumab product, Cosentyx (dosed at 300mg every 14 days), an infliximab product, AND an ustekinumab product:**
   - A. Bimzelx® (bimekizumab)

Product being requested: _____

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Does the member have a diagnosis of moderate to severe (Hurley Stage II or III) Hidradenitis Suppurativa?	☐	☐	**Please provide documentation**
2. Is the requesting provider a dermatologist or in consultation with a dermatologist?	☐	☐	
3. Has smoking cessation, weight management, diet, and proper hygiene counseling been discussed with the member?	☐	☐	**Please provide documentation**
4. Has the member had an inadequate response to ≥ 90 day trial of oral antibiotics, unless contraindicated?	☐	☐	**Please provide documentation**

5. Has the provider performed tuberculosis (TB) screening prior to therapy initiation?	☐	☐	**Please provide documentation**
6. Has the provider performed hepatitis B screening prior to therapy initiation?	☐	☐	**Please provide documentation**

COSENTYX®			
1. Has the member tried and failed, or have a contraindication to an adalimumab product and an infliximab product?	☐	☐	**Please provide documentation**
2. Has baseline lesion count been documented?	☐	☐	**Please provide documentation**
3. If the request is for 300mg every 14 days, does documentation show the following: • Member has been compliant with 300 mg dosing every 28 days for at least 16 weeks; AND • Clinical documentation shows a positive, yet limited response to therapy?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does clinical documentation show a positive response to therapy defined as a decrease in inflammatory lesion count (abscesses + inflammatory nodules) and no increase in abscesses or draining fistulas when compared with baseline?	☐	☐	**Please provide documentation**
3. Has the provider performed continued tuberculosis monitoring during therapy?	☐	☐	**Please provide documentation**
4. Has the provider performed continued Hepatitis B monitoring in HBV carriers?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician's Signature:			

** Failure to submit clinical documentation to support this request will result in a dismissal of the request.**

Policy: PHARM-HCU-032
Origination Date: 01/01/2022
Reviewed/Revised Date: 06/11/2025
Next Review Date: 06/11/2026
Current Effective Date: 07/01/2025

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
HYPERKALEMIA
Lokelma®, Veltassa®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

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Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred: ☐ Veltassa® (patiromer)
Non-Preferred: ☐ Lokelma® (sodium zirconium cyclosilicate)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Is the request for Hyperkalemia?	☐	☐	
2. Is the member between the ages of 18-80?	☐	☐	
3. Is the request from, or in consultation with, a nephrologist or a cardiologist, or is the member pending hospital discharge?	☐	☐	
4. Does the member have a serum potassium level between 5.5-6.5 mmol/L on two separate screenings?	☐	☐	**Please Provide Documentation**
5. If applicable, has the member tried dietary consultations to limit potassium intake?	☐	☐	**Please Provide Documentation**
6. If applicable, has the member tried discontinuing non-steroidal anti-inflammatories?	☐	☐	**Please Provide Documentation**
7. If applicable, has the member tried discontinuing potassium supplements?	☐	☐	**Please Provide Documentation**
8. If applicable, has the member tried reducing or discontinuing angiotensin enzyme inhibitors (ACEIs), angiotensin II receptor blockers (ARBs), or renin-angiotensin-aldosterone system (RAAS) inhibitors?	☐	☐	**Please Provide Documentation**
9. Has the member had a trial and failure of a loop or thiazide diuretic (excluding potassium-sparing diuretics)?	☐	☐	**Please Provide Documentation**

10. Is the requested medication being used to bridge a member with stage 5 kidney dysfunction to dialysis?	☐	☐	
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does updated clinical documentation show that the member's serum potassium is <5.5 mmol/L secondary to the use of patiromer (Veltassa)?	☐	☐	**Please Provide Documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:

Physician's Signature:

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy PHARM-HCU-033
Origination Date: 01/01/2022
Reviewed/Revised Date: 12/30/2024
Next Review Date: 12/30/2025
Current Effective Date: 01/01/2025

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM

IRRITABLE BOWEL SYNDROME WITH DIARRHEA (IBS-D)

alosetron hydrochloride, Xifaxan®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ alosetron hydrochloride, ☐ Xifaxan® (rifaximin)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Has the member been diagnosed with irritable bowel syndrome with diarrhea?	☐	☐	
2. Is the requesting provider a gastroenterologist?	☐	☐	
3. Has the member had a trial and failure of nutritional and/or behavioral therapy (e.g. lactose restriction, gluten-free, low carb, increased physical activity, etc.)?	☐	☐	**Please provide documentation**
4. Has the member had a trial and failure of, or contraindication to, at least one antidiarrheal (e.g. loperamide, diphenoxylate)?	☐	☐	**Please provide documentation**
5. Has the member had a trial and failure of, or contraindication to, at least one antispasmodic (e.g. dicyclomine, hyoscyamine)?	☐	☐	**Please provide documentation**
6. Has the member had a trial and failure of, or contraindication to, at least one tricyclic antidepressant (e.g. imipramine, desipramine)?	☐	☐	**Please provide documentation**
7. For alosetron hydrochloride: Does the member have any of the following: • History of chronic or severe constipation • History of intestinal obstruction, stricture, toxic megacolon, gastrointestinal perforation and/or adhesions • History of ischemic colitis, impaired intestinal circulation, ulcerative colitis, or Crohn's disease • Active diverticulitis or a history of diverticulitis	☐	☐	

• Concomitant use of fluvoxamine			
REAUTHORIZATION			
1. Is the request for reauthorization?	☐	☐	
2. Does updated clinical documentation show continued medical necessity and disease stabilization or improvement of disease?	☐	☐	**Please provide documentation**
3. Please note: rifampin will only be approved for a maximum of three 14-day courses.	☐	☐	
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician's Signature:			

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-034
Origination Date: 01/01/2022
Reviewed/Revised Date: 05/22/2024
Next Review Date: 05/22/2025
Current Effective Date: 06/01/2024

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
IL5 RECEPTOR ANTAGONIST FOR ASTHMA
Cinqair®, Fasenra®, Nucala®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred: ☐ Fasenra® (benralizumab), ☐ Nucala® (mepolizumab)
Non-Preferred: ☐ Cinqair® (reslizumab)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Is the request for treatment of eosinophilic asthma?	☐	☐	
2. Is the request for the preferred product Fasenra®?	☐	☐	
3. Does documentation show the member's baseline eosinophil count?	☐	☐	**Please provide documentation**
4. Is the member being followed by an asthma specialist (e.g. allergist, immunologist, or pulmonologist)?	☐	☐	
5. Has the member been ≥80% compliant with a high-dose inhaled corticosteroid (ICS)/long-acting inhaled beta-2-agonist (LABA) inhaler for at least the past 5 months?	☐	☐	**Please provide documentation**
6. Does the member have poor asthma control, defined as two or more acute exacerbations in the past 12 months requiring additional medical treatment?	☐	☐	**Please provide documentation**
7. Does documentation show the member's forced expiratory volume (FEV1) is < 80%?	☐	☐	**Please provide documentation**
8. Are underlying conditions or triggers for asthma or pulmonary disease maximally managed?	☐	☐	
9. Is the member an active smoker? If yes, does documentation show that smoking cessation has been addressed?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization?	☐	☐	

2. Does updated documentation show sustained clinical improvement from baseline, such as decreased nighttime awakenings, improved FEV1, reduced missed days from work/school, decreased daytime symptoms, etc.?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:

Physician's Signature:

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-035
Origination Date: 07/25/2018
Reviewed/Revised Date: 12/30/2024
Next Review Date: 12/30/2025
Current Effective Date: 01/01/2025

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
INCRELEX®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being request: ☐ Increlex® (mecasermin rDNA origin)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
INSULIN-LIKE GROWTH HORMONE FACTOR-1 DEFICIENCY			
1. Does the member have a diagnosis of growth failure with severe primary insulin-like growth factor-1 deficiency (IGFD)?	☐	☐	**Please provide documentation**
2. Is the member between the ages of 2-17?	☐	☐	
3. Is the requesting provider a pediatric endocrinologist or in consultation with one?	☐	☐	
4. If 15 years of age or older, does the member have open growth plates confirmed by radiographic imaging?	☐	☐	**Please provide documentation**
5. Is the member's basal insulin-like growth factor-1 (IGF-1) standard deviation score less than or equal to -3.0 for age and sex?	☐	☐	**Please provide documentation**
6. Is the member's height standard deviation score less than or equal to -3.0 for age and sex?	☐	☐	**Please provide documentation**
7. Does the member have normal or elevated growth hormone of greater than 10 ng/mL or basal serum growth hormone level greater than 5 ng/mL?	☐	☐	**Please provide documentation**
GROWTH HORMONE GENE DELETION			
1. Does the member have growth failure with growth hormone gene deletion and has developed neutralizing antibodies to growth hormone?	☐	☐	**Please provide documentation**
2. Is the member between the ages of 2-17?	☐	☐	

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3. Is the requesting provider a pediatric endocrinologist or in consultation with one?	☐	☐	
4. If 15 years of age or older, does the member have open growth plates confirmed by radiographic imaging?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. If 15 years of age or older, does the member have open growth plates confirmed by radiographic imaging?	☐	☐	**Please provide documentation**
3. Has the member experienced a growth velocity of ≥2 cm total growth in 1 year?	☐	☐	**Please provide documentation**
4. Has the member reached final adult height?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:

Physician's Signature:

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy PHARM-HCU-036
Origination Date: 01/01/2022
Reviewed/Revised Date: 08/29/2024
Next Review Date: 08/29/2025
Current Effective Date: 09/01/2024

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
INTERSTITIAL CYSTITIS MEDICATIONS
Elmiron®, RIMSO-50®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:

Height/Weight:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Elmiron® (pentosane polysulfate sodium), ☐ RIMSO-50® (dimethyl sulfoxide)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Has the member been clinically diagnosed with interstitial cystitis or bladder pain syndrome?	☐	☐	
2. Has the member had urinary tract symptoms for more than 6 weeks?	☐	☐	**Please provide baseline voiding symptoms and pain levels**
3. Does the member have a urinalysis or urine culture that rules out a urinary tract infection (UTI)?	☐	☐	**Please provide documentation**
4. Have other identifiable causes been ruled out (e.g. overactive bladder, endometriosis and vulvodynia, and prostatitis)?	☐	☐	**Please provide documentation**
5. Is the request made by, or in consultation with, a urologist?	☐	☐	
6. Has the member participated in conservative treatments (e.g. stress management, pain management, and self-care/behavioral modification)?	☐	☐	**Please provide documentation**
7. Has the member had a trial and failure of, or intolerance/contraindication to, amitriptyline and/or cimetidine?	☐	☐	**Please provide documentation**
RIMSO-50			
1. Is the request for RIMSO-50®?	☐	☐	
2. Has heparin or lidocaine been trialed?	☐	☐	**Please provide documentation**
ELMIRON			
1. Is the request for Elmiron®?	☐	☐	

2. Has the member had a trial and failure or contraindication/intolerance to at least 2 intravesical agents (e.g. dimethyl sulfoxide, heparin, or lidocaine)?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the medication shown efficacy, defined as improvement in baseline voiding symptoms and pain levels?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:

Physician's Signature:

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy PHARM-HCU-039
Origination Date: 01/01/2022
Reviewed/Revised Date: 11/13/2024
Next Review Date: 11/13/2025
Current Effective Date: 12/01/2024

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
JUVENILE IDIOPATHIC ARTHRITIS MEDICATIONS

Avsola® Enbrel®, Hadlima™, Humira®, Inflectra®, infliximab,
Kevzara®, Orencia®, Remicade®, Renflexis®, Simlandi®, Tyenne®, Xeljanz/XR®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department.

- For **Medical Pharmacy** please fax requests to: 801-646-7300
- For **Retail Pharmacy** please fax requests to: 385-425-4052

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-formulary drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred/Non-Formulary:

1. **1st Line Preferred Agents:**
   - A. Hadlima™ (adalimumab-bwwd), Simlandi® (adalimumab-ryvk)
   - B. Infliximab products: [Avsola® (infliximab-axxq), Inflectra® (infliximab-dyyb), infliximab, Remicade (infliximab), Renflexis® (infliximab-abda)]
   - C. Tyenne® (tocilizumab-aazg)
   - D. Orencia® (abatacept)
2. **2nd line preferred agents with single step; after trial and failure of BOTH Hadlima or Simlandi and a preferred infliximab agent:**
   - A. Kevzara® (sarilumab), Xeljanz® (tofacitinib)†
     †Note Xeljanz XR is not FDA approved for JIA
3. **Non-Formulary Brands; after trial and failure of Hadlima or Simlandi, a preferred infliximab agent, and Xeljanz †:**
   - A. Enbrel® (etanercept), Rinvoq® (upadacitinib), Humira® (adalimumab)

Product being requested: _____

Dosing/Frequency: _____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Does the member have a documented diagnosis of Juvenile Idiopathic Arthritis?	☐	☐	**Please provide documentation**
2. Is the requesting prescriber a rheumatologist or working in consultation with a rheumatologist?	☐	☐	

3. Has the provider performed tuberculosis (TB) screening prior to therapy initiation?	☐	☐	**Please provide documentation**
4. If the request is for a Tumor Necrosis Factor Inhibitor or Orencia®, has the provider performed hepatitis B screening prior to therapy initiation?	☐	☐	**Please provide documentation**
5. If the request is for Xejanz/XR, does documentation show an inadequate response or intolerance to at least one tumor necrosis factor (TNF) blocker such as an infliximab product, Cimzia, an adalimumab prodcut and/or Simponi AND does documentation show the member will not be receiving Xeljanz/XR in combination with a potent immunosuppressant (e.g., azathioprine or cyclosporine)?	☐	☐	**Please provide documentation**
ACTIVE JOINT COUNT ≤ 4 WITHOUT SYSTEMIC FEATURES			
1. Does the member have an active joint count of **≤ 4** *without* systemic features?	☐	☐	**Please provide documentation**
2. Has the member had an adequate trial of, or intolerance/contraindication to, a nonsteroidal anti-inflammatory drug (NSAID)?	☐	☐	**Please provide documentation**
3. Has the member had an adequate trial of, or intolerance/contraindication to, methotrexate or leflunomide?	☐	☐	**Please provide documentation**
4. Is the request for the preferred product, Humira®?	☐	☐	
ACTIVE JOINT COUNT > 4 WITHOUT SYSTEMIC FEATURES			
1. Does the member have an active joint count of **> 4** *without* systemic features?	☐	☐	**Please provide documentation**
2. Has the member had a 3-month trial of, or intolerance/contraindication to, methotrexate or leflunomide?	☐	☐	**Please provide documentation**
MILD TO MODERATE ACUTE DISEASE WITH SYSTEMIC FEATURES			
1. Does the member have mild to moderate acute disease with systemic features of nondisabling symptoms without evidence of macrophage activation syndrome?	☐	☐	**Please provide documentation**
2. Has the member had an adequate trial of, or intolerance/contraindication to, a nonsteroidal anti-inflammatory drug (NSAID)?	☐	☐	**Please provide documentation**
MODERATE TO SEVERE ACUTE DISEASE WITH SYSTEMIC FEATURES			
1. Has the member shown systemic symptoms such as high fevers with poor response to NSAIDs, other serious systemic manifestations including serositis and possible early macrophage activation syndrome, and/or moderate-to-severe polyarthritis?	☐	☐	**Please provide documentation**
SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (JIA)			
1. Does the member have mild to moderate systemic JIA?	☐	☐	**Please provide documentation**
2. Has the member had an adequate trial of NSAIDs?	☐	☐	
3. Does the member have moderate to severe systemic JIA?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member's therapy been re-evaluated within the past 12 months?	☐	☐	
3. Has the therapy shown to be tolerable and effective with a decrease or stabilization in disease severity?	☐	☐	**Please provide documentation**
4. Does the member show a continued medical need for the therapy?	☐	☐	**Please provide documentation**

5. Has the provider performed continued tuberculosis monitoring during therapy?	☐	☐	**Please provide documentation**
6. Has the provider performed continued Hepatitis B monitoring in HBV carriers?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.
Additional information:
Physician's Signature:

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-041
Origination Date: 01/01/2022
Reviewed/Revised Date: 12/24/2024
Next Review Date: 12/24/2025
Current Effective Date: 01/01/2025

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
MULTIPLE SCLEROSIS AGENTS

Aubagio®, Avonex®, Bafiertam™, Betaseron®, Briumvi®, Copaxone®, Extavia®, Gilenya®, Glatopa®, H.P. Acthar Gel®, Kesimpta®, Lemtrada®, Mavenclad®, Mayzent®, Ocrevus®, Plegridy®, Ponvory®, Rebif®, Rituxan®, Tecfidera®, Tysabri®, Vumerity®, Zeposia®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department.

- For **Medical Pharmacy** please fax requests to: 801-646-7300
- For **Retail Pharmacy** please fax requests to: 385-425-4052

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred: ☐ Betaseron® (interferon beta-1a), ☐ dimethyl fumarate*, ☐ fingolimod*, ☐ glatiramer acetate*, ☐ Rebif® (interferon beta-1a), ☐ preferred rituximab products*, ☐ teriflunomide
* do not require prior authorization

Non-Preferred with a Single Step (trial and failure of dimethyl fumarate, fingolimod, or a rituximab biosimilar OR a contraindication to all THREE): ☐ Briumvi (ublituximab), ☐ Kesimpta® (ofatumumab), ☐ Mayzent® (siponimod), ☐ Ocrevus® (ocelizumab), ☐ Tysabri® (natalizumab)

Non-Formulary: ☐ Aubagio® (teriflunomide), ☐ Avonex® (interferon beta-1a), ☐ Bafiertam™ (monomethyl fumarate), ☐ Copaxone® (glatiramer acetate), ☐ Extavia® (interferon beta-1a), ☐ Gilenya® (fingolimod), ☐ Glatopa® (glatiramer acetate), ☐ H.P. Acthar Gel® (repository corticotropin injection), ☐ Lemtrada® (alemtuzumab), ☐ Mavenclad® (cladribine), ☐ Plegridy® (peginterferon beta-1a), ☐ Ponvory® (ponesimod), ☐ Tecfidera® (dimethyl fumarate), ☐ Vumerity® (diroximel fumarate), ☐ Zeposia® (ozanimod)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Does the member have a diagnosis of Multiple Sclerosis?	☐	☐	**Please provide documentation**
2. Is the member 18 years of age or older?	☐	☐	
3. Is the prescriber a neurologist or working in consultation with a neurologist?	☐	☐	

H.P. ACTHAR GEL®			
1. Has the member tried or has a contraindication to all preferred and non-preferred agents taken at the maximum-tolerated FDA approved dose for at least 3 months each?	☐	☐	**Please provide documentation**
OCREVUS®			
1. Does the member have a diagnosis of primary progressive multiple sclerosis?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member's therapy been re-evaluated with a neurologist within the past 12 months?	☐	☐	
3. Has the therapy shown to be effective with evidence of a positive clinical response?	☐	☐	**Please provide documentation**
4. Does the member show a continued medical need for therapy?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician's Signature:			

****Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy PHARM-HCU-044
Origination Date: 01/01/2022
Reviewed/Revised Date: 11/13/2024
Next Review Date: 11/13/2025
Current Effective Date: 12/01/2024

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
PULMOZYME®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being request: ☐ Pulmozyme® (dornase alfa)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Does the member have a confirmed laboratory diagnosis of cystic fibrosis?	☐	☐	
2. Is the prescriber a pulmonologist or a physician with expertise in caring for cystic fibrosis patients?	☐	☐	
3. Has the member had a trial and failure to hypertonic saline?	☐	☐	**Please provide documentation**
4. If requesting twice daily dose of Pulmozyme®, has the member trialed once daily dosing?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member's therapy been re-evaluated within the past 6 months?	☐	☐	
3. Has the therapy shown to be effective with an improvement or stabilization in condition?	☐	☐	**Please provide documentation**
4. Does the member show a continued medical need for the therapy?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:
Physician's Signature:

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-045
Origination Date: 01/01/2022
Reviewed/Revised Date: 08/29/2024
Next Review Date: 08/29/2025
Current Effective Date: 09/01/2024

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
NEUPRO® FOR RESTLESS LEGS

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being request: ☐ Neupro® (rotigotine)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Is the request for moderate-to-severe Restless Legs Syndrome?	☐	☐	
2. If serum ferritin levels are ≤75 mcg/L, has the member had a 3-month trial and failure of oral iron?	☐	☐	**Please provide documentation**
3. Has the patient tried and failed all of the following: ropinirole, pramipexole, pregabalin?	☐	☐	**Please provide documentation**
4. Is the patient unable to take medications by mouth or is oral therapy clinically inappropriate?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Do updated progress notes show continued medical necessity and clinical efficacy?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:
Physician's Signature:

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy PHARM-HCU-047
Origination Date: 01/01/2022
Reviewed/Revised Date: 05/11/2023
Next Review Date: 05/11/2024
Current Effective Date: 06/01/2023

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
CHRONIC OPIOID MEDICATIONS
Chronic Opioid Medications

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:

Height/Weight:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: _____

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
NON-CANCER, CHRONIC PAIN TOTAL MME < 60			
1. Does the member have a diagnosis of active cancer? If yes, no further assessment is required.	☐	☐	**Please provide documentation**
2. Has the member signed a pain contract or informed consent and treatment agreement for chronic opioid therapy?	☐	☐	**Please provide documentation**
3. Does documentation show that the prescriber has monitored the member's urine drug screen results within the last 12 months?	☐	☐	**Please provide documentation**
NON-CANCER, CHRONIC PAIN TOTAL MME ≥ 60			
1. Does the member have a diagnosis of active cancer? If yes, no further assessment is required.	☐	☐	**Please provide documentation**
2. Will the requested therapy exceed 200 morphine milligram equivalents (MME) per day? **If yes, an active taper plan is required for authorization.**	☐	☐	**Please provide taper plan**
3. Does documentation show that non-pharmacologic treatments such as physical therapy, cognitive behavioral therapy, etc. have been tried but are inadequate?	☐	☐	**Please provide documentation**
4. Does documentation show a trial and failure of non-opioid medications (e.g., acetaminophen, NSAIDs, antidepressants, muscle relaxants, topical analgesics, etc.)?	☐	☐	**Please provide documentation, including**

			names, dates, and durations of treatments
5. Does the member's pain impact their ability to perform activities of daily living and/or is causing significant psychological issues?	☐	☐	**Please provide documentation**
6. Is there a treatment plan in place that outlines the goals of therapy and how the member's progress will be evaluated (e.g., pain levels, functional status, etc. from baseline)?	☐	☐	**Please provide documentation**
7. Has the member signed a pain contract or informed consent and treatment agreement for chronic opioid therapy?	☐	☐	**Please provide documentation**
8. Does documentation show that the prescriber has monitored the member's urine drug screen results within the last 12 months?	☐	☐	**Please provide documentation**
9. Has the member been offered a prescription and training for nasally administered naloxone?	☐	☐	
10. Is the requested therapy for opioid addiction treatment?	☐	☐	**Please provide documentation**
11. Is the member being treated with duplicate short-acting opioids? **Documentation showing that a single short-acting agent is not sufficient or appropriate, is required.**	☐	☐	**Please provide documentation**
12. Is the member also being treated with a benzodiazepine (e.g., lorazepam, alprazolam, etc.)? **Documentation showing medical necessity is required.**	☐	☐	**Please provide documentation**
13. Is the member also being treated with carisoprodol (Soma)? **Opioid treatment in combination with carisoprodol will not be covered.**	☐	☐	**Please provide documentation**
14. Is the prescriber reviewing the member's history of controlled substance prescriptions using the states prescription drug monitoring program at least every 3 months?	☐	☐	**Please provide documentation**
LONG ACTING OPIOIDS			
1. Is the request for a long-acting opioid?	☐	☐	
2. Does the member require daily, around-the-clock long-term opioid treatment?	☐	☐	**Please provide documentation**
3. Has the member tried and failed short-acting opioids along with non-pharmacological therapy?	☐	☐	**Please provide documentation**
4. Is the member currently on opioid therapy that is at least 20 MMEs per day?	☐	☐	**Please provide documentation**
5. Does the member have a past or current substance abuse potential? **Documentation showing medical necessity for opioid treatment is required.**	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member shown objective progress toward treatment plan goals?	☐	☐	**Please provide documentation**
3. Has the member continued to utilize physical, behavioral, and non-opioid therapies in combination with chronic opioid therapy?	☐	☐	**Please provide documentation**

4. Has a random drug screen been performed within the past 12 months?	☐	☐	**Please provide documentation**
5. Do the member's medication records correspond with medical reasons for continuing or modifying opioid therapy (i.e., medication, dose, and quantities prescribed)?	☐	☐	

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:

Physician Signature:

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy PHARM-HCU-051
Origination Date: 01/01/2022
Reviewed/Revised Date: 03/18/2025
Next Review Date: 03/18/2026
Current Effective Date: 04/01/2025

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
Acute Opioid Use Policy

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Does the member have a diagnosis of active cancer? **If documentation supports active cancer therapy, no additional questions are required.**	☐	☐	**Please provide documentation**
2. Does the member have one of the following: post-operative pain requiring opioid therapy expected to last longer than 7 days, treatment of nocturnal dyspnea, or treatment of acute sickle cell crisis?	☐	☐	**Please provide documentation, including names, dates, and durations of treatments**
3. Does the member require no more than 7-day supply, except dental use (limit to a 3 days supply)?	☐	☐	
4. Does the member require continuous opioid use beyond 30 days? If yes, see Chronic Opioid Policy.	☐	☐	
5. Is the member new to the plan and currently taking chronic short-acting opioid therapy? If yes, see Chronic Opioid Policy.	☐	☐	
6. Does the member require long-acting opioid for acute pain treatment? If yes, see Chronic Opioid Policy.	☐	☐	

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:
Physician’s Signature:

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy PHARM-HCU-052
Origination Date: 08/21/2017
Reviewed/Revised Date: 12/30/2024
Next Review Date: 12/30/2025
Current Effective Date: 01/01/2025

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
OSTEOPOROSIS MEDICATIONS
Evenity®, teriparatide, Tymlos®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred: ☐ Evenity® (romosozumab), ☐ teriparatide, ☐ Tymlos® (abaloparatide)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Does the member have a documented diagnosis of one of the following: • Postmenopausal female with osteoporosis, • Male with primary or hypogonadal osteoporosis, • Osteoporosis likely caused by systemic glucocorticoid therapy?	☐	☐	**Please provide documentation**
2. Is the member considered high risk for fracture, defined by meeting one of the following: • History of recent fragility fracture or bone mineral density measurement showing osteoporosis (T-score ≤ -2.5), • History of previous fractures and/or glucocorticoid use for at least 3 months and osteopenia (T-Score between -1 and -2.5)?	☐	☐	**Please provide documentation**
3. Does the member have severe osteoporosis, defined as one of the following: • T-score ≤ -2.5 plus a recent fragility fracture • T-score ≤ -3.5 and at high risk for fragility fracture based on FRAX score	☐	☐	**Please provide documentation**
4. Does documentation show a 24-month trial and failure (defined as progression of bone loss) of at least one bisphosphonate (i.e.	☐	☐	**Please provide documentation**

alendronate, ibandronate, risedronate, intravenous zoledronic acid), unless contraindicated? • IV therapy (zoledronic acid) is required if the member is unable to tolerate oral bisphosphonate or has an absorption disorder.			
5. Does documentation show a 24-month trial and failure of Prolia®, unless contraindicated?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician's Signature:			

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-054
Origination Date: 01/01/2022
Reviewed/Revised Date: 08/29/2024
Next Review Date: 08/29/2025
Current Effective Date: 09/01/2024

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
PHENYLBUTYRATES
Buphenyl®, Pheburane®, Ravicti®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:

Height/Weight:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred: ☐ sodium phenylbutyrate powder, ☐ sodium phenylbutyrate tablets
Preferred after trial and failure of one of sodium phenylbutyrate powder or tablets: ☐ Pheburane® (sodium phenylbutyrate)
Non-preferred: ☐ Ravicti® (glycerol phenylbutyrate)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Does the member have a diagnosis of urea cycle disorder requiring chronic management that is confirmed by enzymatic, biochemical or genetic testing?	☐	☐	**Please provide documentation**
2. Does documentation show that the member's condition has not been managed adequately by dietary protein restriction and/or amino acid supplementation alone?	☐	☐	**Please provide documentation**
3. Has a nutritional consultation been performed to assess diet?	☐	☐	**Please provide documentation**
4. Will phenylbutyrate be used in combination with a dietary protein restriction?	☐	☐	
5. Does the requesting provider have experience managing urea cycle disorder?	☐	☐	
6. Is the request for Ravicti®? **Please note: For Ravicti®, treatment failure for "bad taste" or "taste aversion" will only be allowed in members ≤11 years old.**	☐	☐	
7. Has the member tried and failed or have a contraindication to sodium phenylbutyrate? (Contraindications may include comorbid conditions which limit sodium intake, such as heart failure, renal impairment, hypertension and edema)	☐	☐	**Please provide documentation**

REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does updated documentation show a continued medical necessity and clinical efficacy of therapy?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician's Signature:			

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-058
Origination Date: 01/01/2022
Reviewed/Revised Date: 06/11/2025
Next Review Date: 06/11/2026
Current Effective Date: 07/01/2025

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
PHENYLKENTONUIRA
Kuvan®, Palynziq®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred: ☐ Sapropterin dihydrochloride
Non-preferred: ☐ Palynziq® (pegvaliase-pqpz)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Does the member have a confirmed diagnosis of phenylketonuria?	☐	☐	**Please provide documentation**
2. Is the member followed by a physician who specializes in metabolic diseases?	☐	☐	
3. Is the member followed by a dietician who specializes in PKU/metabolic diseases?	☐	☐	
4. Has the member been compliant with and failed a phenylalanine restricted diet for at least 6 months?	☐	☐	**Please provide documentation**
5. Do average Phe levels within 2 weeks of therapy initiation show the following? • *>6 mg/dL for ages 1 month to 12 years* • *>15 mg/dL after the age of 12* • *>6 mg/dL in pregnancy.*	☐	☐	**Please provide documentation**
PALYNZIQ®			
1. Is sapropterin dihydrochloride or Palynziq® being requested to liberalize a strict phenylalanine restricted diet? Authorization will not be provided for liberalizing diet or in non-compliant patients.	☐	☐	
2. Has a trial and failure of the maximally tolerated dose of sapropterin dihydrochloride been demonstrated?	☐	☐	**Please provide documentation**

3. In women of childbearing potential, will contraception be used prior to and during treatment?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member remained compliant with a phenylalanine-restricted diet?	☐	☐	**Please provide documentation**
3. Has there been a documented positive clinical response from treatment? • Defined as a ≥20% decrease from baseline in Phe levels after 12 weeks or maintenance of initial reduction.	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:

Physician's Signature:

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request. ****

Policy: PHARM-HCU- 059
Origination Date: 01/01/2022
Reviewed/Revised Date: 06/11/2025
Next Review Date: 06/11/2026
Current Effective Date: 07/01/2025

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
PROMACTA®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Promacta® (eltrombopag) tablets, ☐ Promacta® (eltrombopag) packets

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
CHRONIC OR PERSISTENT IMMUNE/IDIOPATHIC THROMBOCYTOPENIA (ITP)			
1. Does the member have a diagnosis of chronic or persistent (>6 months) immune/idiopathic thrombocytopenia (ITP)?	☐	☐	**Please provide documentation**
2. Does documentation show a platelet count < 30,000/mcL?	☐	☐	**Please provide documentation**
3. Is the requesting provider a hematologist or oncologist?	☐	☐	
4. Has the member had a trial and failure of corticosteroids? • Adequate trial is defined as prednisone (0.5 - 2.0 mg/kg/day) or dexamethasone 40mg once daily for 4 days, may be repeated up to 3 times if inadequate response • Failure is defined as platelet count not increasing to at least 50,000/mcL or continued requirement for steroids after 3 months of treatment	☐	☐	**Please provide documentation**
CHRONIC HEPATITIS C- ASSOCIATED THROMBOCYTOPENIA			
1. Does the member have a diagnosis Chronic Hepatitis C-associated thrombocytopenia?	☐	☐	**Please provide documentation**
2. Is the requesting provider a gastroenterologist, infectious disease specialist, or a hematologist?	☐	☐	
3. Is the member's platelet count < 75,000/mcL?	☐	☐	**Please provide documentation**
4. Has the member been prescribed interferon for the treatment of Chronic Hepatitis C, but is unable to initiate therapy or maintain therapy due to the degree of thrombocytopenia?	☐	☐	**Please provide documentation**

SEVERE APLASTIC ANEMIA			
1. Does the member have a confirmed diagnosis of Severe Aplastic Anemia?	☐	☐	
2. Is the requesting provider a hematologist?	☐	☐	
3. Does documentation show bone marrow cellularity less than 25% or 25-50% if less than 30% of residual cells are hematopoietic?	☐	☐	**Please provide documentation**
4. Does documentation show at least two of the following? • Absolute neutrophil count (ANC) < 500/mL • Platelet count < 20,000/mcL • Reticulocyte count < 20,000/mcL	☐	☐	**Please provide documentation**
5. Has the member had a 3-month trial and failure of standard immunosuppressive therapy (e.g. cyclosporine, anti-thymocyte globulin, or cyclophosphamide)?	☐	☐	**Please provide documentation**
PROMACTA PACKETS FOR SUSPENSION			
1. Is the member less than 8 years of age?	☐	☐	
2. Does documentation show the member is unable to swallow or has severe dysphagia preventing the member from taking solid oral medications?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
CHRONIC OR PERSISTENT IMMUNE/IDIOPATHIC THROMBOCYTOPENIA (ITP)			
1. Is the request for reauthorization of therapy for ITP?	☐	☐	
2. Has the member responded to therapy, defined as a platelet count of at least 50,000/mcL?	☐	☐	**Please provide documentation**
CHRONIC HEPATITIS C- ASSOCIATED WITH THROMBOCYTOPENIA			
1. Is the request for reauthorization of therapy for Chronic Hepatitis C-associated with thrombocytopenia?			
2. Has the member responded to treatment, defined as normalization in platelet count and the member continues on interferon therapy for the treatment of chronic hepatitis C?	☐	☐	**Please provide documentation**
SEVERE APLASTIC ANEMIA			
1. Is the request for reauthorization of therapy for severe aplastic anemia?	☐	☐	
2. Has the member responded to therapy, defined as at least one of the following? • Platelet increase of at least 20,000/mcL above baseline • Transfusion independent and stable platelet counts for at least 8 weeks • Hemoglobin increase by at least 1.5g/dL • Reduction in red blood cell transfusions of at least 4 units for at least 8 weeks • Absolute neutrophil count increase of 100% or increase of at least 500/mcL	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			

Additional information:
Physician's Signature:

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy PHARM-HCU-060
Origination Date: 01/01/2022
Reviewed/Revised Date: 07/29/2024
Next Review Date: 07/29/2025
Current Effective Date: 08/01/2024

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM

PSORIASIS

Avsola®, Bimzelx®, Cimzia®, Cosentyx®, Enbrel®, Hadlima™, Ilumya®, Inflectra®, infliximab, Otezla®, Remicade®, Renflexis®, Siliq™, Simlandi®, Skyrizi®, Sotyktu™, Spevigo®, Taltz®, Tremfya®, Yesintek™

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department.

- For **Medical Pharmacy** please fax requests to: 801-646-7300
- For **Retail Pharmacy** please fax requests to: 385-425-4052

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-formulary drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred/Non-Formulary:

1. **1st Line Preferred Agents:**
   - A. Hadlima™ (adalimumab-bwwd), Simlandi® (adalimumab-ryvk)
   - B. Infliximab products: Avsola® (infliximab-axxq), Inflectra® (infliximab-dyyb), infliximab, Remicade (infliximab), Renflexis® (infliximab-abda)
   - C. Yesintek™ (ustekinumab-kfce)
2. **2nd line preferred agents with single step; after trial and failure of an adalimumab product, an ustekinumab product and an infliximab product:**
   - A. Cimzia® (certolizumab), Otezla® (apremilast), Taltz® (ixekizumab)
3. **Non-Formulary Agents with a triple step; after trial and failure of an adalimumab product, an ustekinumab product, an infliximab product, and 2 second line agents:**
   - A. Bimzelx® (bimekizumab), Enbrel® (etanercept), Ilumya® (tildrakizumab), Siliq™ (brodalumab), Sotyktu™ (deucravacitinib), Spevigo® (spesolimab)
4. **Non-Formulary Agents after trial and failure of all of the above:**
   - A. Cosentyx® (secukinumab), Skyrizi® (risankizumab-rzaa), Tremfya® (guselkumab)

Product being requested: _____

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Is the request made by a dermatologist or made in consultation with a dermatologist?	☐	☐	
2. Does the member have moderate to severe psoriasis disease based on the Psoriasis Area and Severity Index (PASI) and/or Body Surface Area Percentage (BSA%) **OR** high impact disease (plaques on palms/soles, scalp psoriasis, nail psoriasis)? **Note:** Otezla does not require documentation of severity	☐	☐	**Please provide documentation**

3. Has the member had an adequate trial and failure of, or contraindication to, phototherapy or photochemotherapy?	☐	☐	**Please provide documentation**
4. Has the member had an adequate trial and failure of at least one, or contraindication to all three, of the following: methotrexate, cyclosporine A, and acitretin?	☐	☐	**Please provide documentation**
5. Has the provider performed tuberculosis (TB) screening prior to therapy initiation? (Note: NOT required if the request is for Otezla)	☐	☐	**Please provide documentation**
6. If the request is for a Tumor Necrosis Factor Inhibitor, has the provider performed hepatitis B screening prior to therapy initiation?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member's therapy been re-evaluated within the past 6 months?	☐	☐	
3. Has the therapy shown to be tolerable and effective with an improvement in condition?	☐	☐	**Please provide documentation**
4. Does the member show a continued medical need for the therapy?	☐	☐	**Please provide documentation**
5. Has the provider performed continued tuberculosis monitoring during therapy?	☐	☐	**Please provide documentation**
6. Has the provider performed continued Hepatitis B monitoring in HBV carriers?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

****Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-061
Origination Date: 01/01/2022
Reviewed/Revised Date: 04/09/2025
Next Review Date: 04/09/2026
Current Effective Date: 05/01/2025

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM

PSORIATIC ARTHRITIS

Avsola®, Bimzelx®, Cimzia®, Cosentyx®, Enbrel®, Hadlima™, Inflectra®, infliximab, Orencia®, Otezla®, Remicade®, Renflexis®, Rinvoq®, Simlandi®, Simponi®, Skyrizi®, Taltz®, Tremfya®, Xeljanz/XR®, Yesintek™

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department.

- For **Medical Pharmacy** please fax requests to: 801-646-7300
- For **Retail Pharmacy** please fax requests to: 385-425-4052

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-formulary drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred/Non-Formulary

1. **1st Line Preferred Agents:**
   - A. Hadlima™ (adalimumab-bwwd), Simlandi® (adalimumab-ryvk)
   - B. Infliximab products: Avsola® (infliximab-axxq), Inflectra® (infliximab-dyyb), infliximab, Remicade (infliximab), Renflexis® (infliximab-abda)
   - C. Yesintek™ (ustekinumab-kfce)
2. **2nd line preferred agents with single step; after trial and failure of an adalimumab agent, an ustekinumab agent and an infliximab agent:**
   - A. Cimzia® (certolizumab), Orencia® (abatacept), Otezla® (apremilast), Taltz® (ixekizumab), Xeljanz/XR ® (tofacitinib)
3. **Non-Formulary Agents with a triple step; after trial and failure of an adalimumab agent, an ustekinumab agent, an infliximab agent and 2 second line agents:**
   - A. Bimzelx® (bimekizumab), Enbrel® (etanercept), Rinvoq® (upadacitinib), Simponi® (golimumab),
4. **Non-Formulary Agents; after trial and failure of all of the above:**
   - A. Cosentyx® (secukinumab), Skyrizi® (risankizumab-rzaa), Tremfya® (guselkumab)

Product being requested: _____

Dosing/Frequency: _____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Is the patient 18 years of age or older with active psoriatic arthritis?	☐	☐	**Please provide documentation**
2. Is the request from, or in consultation with, a rheumatologist or a dermatologist?	☐	☐	

3. Has the patient had an adequate trial and failure of at least one of the following disease-modifying antirheumatic drugs (DMARDs), unless contraindicated to all: methotrexate, leflunomide, sulfasalazine, azathioprine, intra-articular glucocorticoid injections, hydroxychloroquine, D-penicillamine, or minocycline?	☐	☐	**Please provide documentation**
4. Does the member have moderate axial disease, severe disease, or enthesitis? • For patients with moderate axial disease, severe disease, or enthesitis, a trial and failure of a DMARD may not be necessary.	☐	☐	**Please provide documentation**
5. If the request is for Rinvoq® or Xeljanz/XR®, does documentation show inadequate response or intolerance to at least one TNF (tumor necrosis factor) blocker such as an infliximab, Cimzia, an adalimumab product and/or Simponi AND does documentation show the member will not be receiving Rinvoq® or Xeljanz/XR® in combination with a potent immunosuppressant (e.g., azathioprine or cyclosporine)?	☐	☐	**Please provide documentation**
6. If the request is for a Tumor Necrosis Factor Inhibitor or an Interleukin Receptor Antagonist, has the provider performed tuberculosis (TB) screening prior to therapy initiation?	☐	☐	**Please provide documentation**
7. If the request is for a Tumor Necrosis Factor Inhibitor, has the provider performed hepatitis B screening prior to therapy initiation?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member's therapy been re-evaluated within the past 12 months?	☐	☐	
3. Has the therapy shown to be tolerable and effective with a significant decrease in disease severity?	☐	☐	**Please provide documentation**
4. Does the member show a continued medical need for the therapy?	☐	☐	**Please provide documentation**
5. Has the provider performed continued tuberculosis monitoring during therapy?	☐	☐	**Please provide documentation**
6. Has the provider performed continued Hepatitis B monitoring in HBV carriers?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			

Physician's Signature:

****Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-062
Origination Date: 01/01/2022
Reviewed/Revised Date: 04/09/2025
Next Review Date: 04/09/2026
Current Effective Date: 05/01/2025

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
PULMONARY ARTERIAL HYPERTENSION (PAH) MEDICATIONS

Adempas®, Flolan®, Letairis®, Opsumit®, Orenitram®, Remodulin®, Tracleer®, Tyvaso®, Uptravi®, Veletri®, Ventavis®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department.

- For **Medical Pharmacy** please fax requests to: 801-646-7300
- For **Retail Pharmacy** please fax requests to: 385-425-4052

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred: ☐ ambrisentan, ☐ epoprostenol, ☐ Orenitram® tablets, ☐ treprostinil intravenous, ☐ Uptravi® (selexipag)
Non-preferred: ☐ Adempas® (riociguat), ☐ bosentan, ☐ Opsumit® (macitentan), ☐ Ventavis® solution for inhalation
Non-Formulary: ☐ Remodulin® (treprostinil), ☐ Tracleer® (bosentan), ☐ Tyvaso® solution for inhalation, ☐ Tyvaso® DPI

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Does the member have a diagnosis of Pulmonary Arterial Hypertension (PAH)?	☐	☐	**Please provide documentation**
2. Is the member classified as WHO (World health Organization) Group 1 pulmonary arterial hypertension? If not, please provide the WHO group classification.	☐	☐	**Please provide documentation**
3. Is the requesting provider a cardiologist or pulmonologist specializing in pulmonary hypertension?	☐	☐	
4. Does the member have regular follow up visits with the prescriber?	☐	☐	**Please provide documentation**
5. Has the member demonstrated at least 80% compliance with pulmonary hypertension medications?	☐	☐	**Please provide documentation**
6. If the member has a positive vasoreactivity test, have they had a trial and failure of oral calcium channel blocker therapy with dihydropyridine or diltiazem?	☐	☐	**Please provide documentation**
7. Has the member performed a baseline 6-minute walk test?	☐	☐	**Please provide documentation**

8. Is the member currently smoking or vaping?	☐	☐	
9. For member with a history of stimulant drug abuse, has a recent (within the past 30 days) clean urine drug screen (UDS) been provided?	☐	☐	**Please provide documentation**
ENDOTHELIN RECEPTOR ANTAGONISTS: AMBRISENTAN, BOSENTAN, OPSUMIT®			
1. Will the medication be used in combination with a phosphodiesterase inhibitor?	☐	☐	**Please provide documentation**
2. If the request is for Opsumit®, has ambrisentan been trialed and failed?	☐	☐	**Please provide documentation**
PROSTACYCLIN PATHWAY AGONISTS: ORENITRAM®, TREPROSTINIL IV, TREPROSTINIL SQ, REMODULIN®, UPTRAVI®			
1. Is the member in WHO functional class II?	☐	☐	**Please provide documentation**
2. Is the member in WHO functional class III or IV?	☐	☐	**Please provide documentation**
3. Has the member tried and failed a PDE5 inhibitor in combination with ambrisentan or bosentan?	☐	☐	**Please provide documentation**
PROSTACYCLIN PATHWAY AGONISTS: TYVASO®, TYVASO® DPI, VENTAVIS®			
1. If the member has a clinical diagnosis of WHO group 1 PAH, have they tried and failed a PDE5 inhibitor in combination with ambrisentan or bosentan?	☐	☐	**Please provide documentation**
2. Does the member have WHO Group 3 pulmonary hypertension associated with interstitial lung disease with documentation showing the following: • diagnosis confirmed by right heart catheterization • baseline force vital capacity <70% • evidence of diffuse parenchymal lung disease on computed tomography of the chest?	☐	☐	**Please provide documentation**
3. Has the member had a trial and failure to treprostinil IV or SQ?	☐	☐	**Please provide documentation**
GUANYLATE CYCLASE STIMULATOR: ADEMPAS®			
1. Is the member in WHO functional class II, III or IV?	☐	☐	**Please provide documentation**
2. If the member has a clinical diagnosis of WHO group 1 PAH, have they tried and failed combination therapy with a PDE5 inhibitor with ambrisentan or bosentan?	☐	☐	**Please provide documentation**
3. Does the member have a clinical diagnosis of WHO Group 4 PAH after surgical treatment OR have confirmed inoperable chronic thromboembolic pulmonary hypertension?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does documentation show disease improvement or stabilization (e.g. improvement in 6 minute walk test, functional class, pulmonary arterial pressure, cardiac index, etc.)?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:
Physician's Signature:

****Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy PHARM-HCU-063
Origination Date: 01/01/2022
Reviewed/Revised Date: 11/09/2023
Next Review Date: 11/09/2024

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
RHEUMATOID ARTHRITIS

Avsola®, Cimzia®, Enbrel®, Hadlima™, Humira®, Inflectra®, Kevzara®, Kineret®, Olumiant®, Orencia®, Remicade®, Renflexis®, Riabni®, Rinvoq®, Rituxan®, Ruxience®, Simlandi®, Simponi®, Truxima®, Tyenne®, Xeljanz®/XR

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department.

- For **Medical Pharmacy** please fax requests to: 801-646-7300
- For **Retail Pharmacy** please fax requests to: 385-425-4052

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try at least two formulary preferred drugs before a request for a non-formulary drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred/Non-Formulary:

1. **1st Line Preferred Agents:**
   - A. Hadlima™ (adalimumab-bwwd), Simlandi® (adalimumab-ryvk)
   - B. Infliximab products: Avsola® (infliximab-axxq), Inflectra® (infliximab-dyyb), infliximab, Remicade (infliximab), Renflexis® (infliximab-abda)
   - C. Rituximab biosimilar products: Riabni® (rituximab-arrx), Ruxience® (rituximab-pvvr), Truxima® (rituximab-abbs)
2. **2nd line preferred agents with single step; after trial and failure of BOTH Hadlima™ or Simlandi®, and a preferred infliximab agent:**
   - A. Cimzia® (certolizumab), Kevzara® (sarilumab), Kineret® (anakinra), Olumiant® (baricitinb), Orencia® (abatacept), Tyenne® (tocilizumab-aazg), Xeljanz/XR® (tofacitinib)
3. **Non-Formulary Agents with a triple step; after trial and failure of Hadlima™ or Simlandi®, and a preferred infliximab agent, and 2 second line agents: Non-Formulary Agents with a triple step; after trial and failure of Hadlima™ or Simlandi®, and a preferred infliximab agent, and 2 second line agents:**
   - A. Enbrel® (etanercept), Humira® (adalimumab), Rinvoq® (upadacitinib), Simponi® (golimumab)

Product being requested: _____

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Is the requesting provider a rheumatologist or in consultation with a rheumatologist?	☐	☐	
2. Is the patient's condition moderate to severe based on the Disease Activity Score (DAS28) or is a tender and swollen joint	☐	☐	**Please provide documentation**

count provided as well as C-reactive protein (CRP) or erythrocyte sedimentation rate (ESR)?			
3. Has the patient had an adequate trial and failure of at least one disease modifying antirheumatic drug (DMARD) (e.g. hydroxychloroquine, leflunomide, methotrexate, sulfasalazine) or contraindication to all?	☐	☐	**Please provide documentation**
4. If the request is for Rinvoq, Olumiant, or Xeljanz/XR, does documentation show inadequate response or intolerance to at least one TNF (tumor necrosis factor) blocker such as an infliximab product, Cimzia, an adalimumab product and/or Simponi and does documentation show the member will not be receiving Rinvoq, Olumiant, or Xeljanz/XR in combination with a potent immunosuppressant (e.g., azathioprine or cyclosporine)?	☐	☐	**Please provide documentation**
5. If the request is for a Tumor Necrosis Factor Inhibitor or an Interleukin Receptor Antagonist, has the provider performed tuberculosis (TB) screening prior to therapy initiation?	☐	☐	**Please provide documentation**
6. If the request is for a Tumor Necrosis Factor Inhibitor, has the provider performed hepatitis B screening prior to therapy initiation?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the patient experienced at least a 20% improvement in ACR or DAS28 score since therapy initiation?	☐	☐	**Please provide documentation**
3. Has the provider performed continued tuberculosis monitoring during therapy?	☐	☐	**Please provide documentation**
4. Has the provider performed continued Hepatitis B monitoring in HBV carriers?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician's Signature:			

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-065
Origination Date: 01/01/2022
Reviewed/Revised Date: 12/24/2024
Next Review Date: 12/24/2025
Current Effective Date: 01/01/2025

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
SANDOSTATIN LAR®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department.

- For **Medical Pharmacy** please fax requests to: 801-646-7300
- For **Retail Pharmacy** please fax requests to: 385-425-4052

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Sandostatin® LAR (octreotide)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Has the member had a clinical response and tolerance to immediate-release octreotide prior to depot injection use?	☐	☐	**Please provide documentation**
ACROMEGALY			
2. Has the member had an inadequate response or contraindication to surgery or radiation?	☐	☐	**Please provide documentation**
3. Has the member had an inadequate response or contraindication to a dopamine agonist (i.e., bromocriptine, cabergoline)?	☐	☐	**Please provide documentation**
METASTATIC CARCINOID TUMERS			
1. Does the member have severe diarrhea and flushing associated with metastatic carcinoid tumors?	☐	☐	**Please provide documentation**
VASOACTIVE INTESTINAL PEPTIDE TUMOR (VIPoma)			
1. Does the member have profuse watery diarrhea associated with a Vasoactive Intestinal Peptide Tumor (VIPoma)?	☐	☐	**Please provide documentation**
Gastrointestinal Arterio-Venous Malformations (HEYDE'S SYNDROME)			
1. Is the request for gastrointestinal arteriovenous malformations (e.g. Heyde's Syndrome)?	☐	☐	
NEUROENDOCRINE TUMORS			

1. Is the request for neuroendocrine tumors and in accordance with NCCN guidelines?	☐	☐	
REFRACTORY DIARRHEA ASSOCIATED WITH ACUTE GRAFT VERSUS HOST DISEASE OR CHEMOTHERAPY			
1. Is the request for refractory diarrhea associated with acute graft versus host disease or chemotherapy?	☐	☐	
HIGH OUTPUT FISTULAS			
1. Is the request for high output fistulas?	☐	☐	
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the therapy shown to be effective with a clinically significant response to therapy?	☐	☐	**Please provide documentation**
3. Does the member show a continued medical need for the therapy?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician's Signature:			

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy PHARM-HCU-066
Origination Date: 01/01/2022
Reviewed/Revised Date: 12/30/2024
Next Review Date: 12/30/2025
Current Effective Date: 01/01/2025

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
SAVELLA®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Savella® (milnacipran)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Has the member been diagnosed with fibromyalgia with widespread pain for > 3 months?	☐	☐	**Please provide documentation**
2. Is the member 18 years of age or older?	☐	☐	
3. Has the member had a 3-month trial and failure or contraindication to each of the following: • pregabalin • Tricyclic antidepressants (i.e. amitriptyline) • duloxetine	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does clinical documentation show continued medical necessity and that the member has responded to treatment?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:
Physician Signature:

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy PHARM-HCU-067
Origination Date: 01/01/2022
Reviewed/Revised Date: 09/18/2024
Next Review Date: 09/18/2025
Current Effective Date: 10/01/2024

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
SPRAVATO™

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Spravato™ (esketamine)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
SPRAVATO™			
1. Is the member 18 years of age or older?	☐	☐	
2. Does the member have a diagnosis of moderate to severe major depressive disorder?	☐	☐	**Please provide documentation**
3. If the member is prescribed an antidepressant, has the member been complaint?	☐	☐	
4. Has the member had an inadequate response to at least an 8-week trial of the maximum tolerated dose of at least 3 (three) antidepressants, each from a different class?	☐	☐	**Please provide documentation**
5. Has the member had an inadequate response to intravenous ketamine treatment?	☐	☐	**Please provide documentation**
6. Has the member had an inadequate response to Electroconvulsive therapy (ECT)?	☐	☐	**Please provide documentation**
7. Does the member have a recent history of substance abuse or alcohol use disorder?	☐	☐	
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. If the member is prescribed an antidepressant, has the member been complaint?	☐	☐	
3. Does clinical documentation show continued medical necessity and a positive clinical response?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.
Additional information:
Physician Signature:

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-069
Origination Date: 01/01/2022
Reviewed/Revised Date: 07/29/2024
Next Review Date: 07/29/2025
Current Effective Date: 08/01/2024

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
SUBCUTANEOUS METHOTREXATE
Otrexup®, Rasuvo®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred: ☐ Rasuvo™ (methotrexate)
Non-preferred: ☐ Otrexup® (methotrexate)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section			
Questions	**Yes**	**No**	**Comments/Notes**
1. Has the member been diagnosed with severe, active rheumatoid arthritis or polyarticular juvenile idiopathic arthritis or severe, recalcitrant, disabling psoriasis?	☐	☐	
2. Has the member had a trial and failure with oral methotrexate?	☐	☐	**Please provide documentation**
3. Has the member had a trial and failure, with subcutaneous or intramuscular methotrexate?	☐	☐	**Please provide documentation**
4. Is the member unable to draw up methotrexate from a vial into a syringe or self-administer, due to mechanical, physical, or environmental factors?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member's therapy been re-evaluated within the past 6 months?	☐	☐	
3. Has the therapy shown to be tolerable and effective with an improvement in condition?	☐	☐	**Please provide documentation**
4. Does the member show a continued medical need for the therapy?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.
Additional information:
Physician's Signature:

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy PHARM-HCU-070
Origination Date: 01/01/2022
Reviewed/Revised Date: 12/30/2024
Next Review Date: 12/30/2025
Current Effective Date: 01/01/2025

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
SYNAGIS®

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Gestational Age at Birth (give weeks & days):		Member Weight:

Product being requested: ☐ Synagis® (palivizumab)
Dosing/Frequency:_____
Please note:
Requests may be approved for up to a maximum of 4 to 5 doses at a dosing interval of not less than 28 days between injections.
Requests will only be authorized for treatment during the State Health Department's declared official Synagis® season.
Approved requests will be authorized to start on the first date of the official Synagis® season.
If the member has tested positive for RSV, further requests for Synagis® will not be approved.

Questions	Yes	No	Comments/Notes
1. Was the member's age ≤ 12 months at the start of the RSV season? If no, skip to question #7.	☐	☐	
2. If the member is < 6 months of age, is Beyfortus (nirsevimab) available for administration?	☐	☐	
3. Was the member born before 29 weeks, 0 days gestation? • *Note: Synagis prophylaxis is not recommended for otherwise well infants ≥ 29 weeks gestational age.*	☐	☐	
4. Was the member diagnosed with chronic lung disease of prematurity, defined as gestational age < 32 weeks AND required supplemental oxygen for at least the first 28 days after birth?	☐	☐	
5. Is the member diagnosed with hemodynamically significant congenital heart disease with one of the following: • Cyanotic heart disease, receiving medication to control congestive heart failure?; OR • Member will require cardiac surgical procedures?; OR • Member has moderate to severe pulmonary hypertension? *Note: Synagis® prophylaxis is not recommended for infants with hemodynamically insignificant heart disease, such as secundum atrial septal defect, small ventricular septal defect, pulmonic stenosis, uncomplicated aortic stenosis, mild coarctation of the aorta, or patent ductus arteriosus.*	☐	☐	
6. Does the member have anatomic pulmonary abnormalities or neuromuscular disorders that impairs the ability to clear secretions from the upper airway?	☐	☐	

7. Will the member be profoundly immunocompromised during the respiratory syncytial virus (RSV) season?	☐	☐	
8. Was the member's age ≥ 12 months and <24 months at the start of the RSV season?	☐	☐	
9. Is the member <20 months and expected to receive a heart transplant during the current RSV season?	☐	☐	
10. Is the member <20 months and expected to be profoundly immunocompromised during the current RSV season?	☐	☐	
11. Was the member born at less than 32 weeks 0 days gestation and required at least 28 days of oxygen after birth and continues to require medical intervention with supplemental oxygen, chronic corticosteroids, or diuretic therapy in the 6 months prior to the start of the current RSV season? *Note: Synagis prophylaxis is not recommended for otherwise well infants with chronic lung disease of prematurity who are 12 to 24 months old.*	☐	☐	
12. Has the member had a respiratory syncytial virus-related hospitalization during this RSV season?	☐	☐	
13. Has the member received Beyfortus during this RSV season?	☐	☐	
14. Was Synagis® given while the member was in the hospital (e.g., NBICU, NICU)? If yes, please list dates given: _____	☐	☐	
Physician's Signature:			

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

1. **Synagis® (palivizumab) therapy is authorized according to current guidelines for treatment of RSV as published by the American Academy of Pediatrics Committee on Infectious Diseases; American Academy of Pediatrics Bronchiolitis Guidelines Committee. The current guidelines may be found online at** http://pediatrics.aappublications.org/content/pediatrics/134/2/415.full.pdf.
2. **Synagis® injections may be authorized during the RSV season, as defined by the local State Department of Health.**
3. **Up to 4-5 monthly doses may be authorized. Infants born during the RSV season, and who are approved for Synagis® therapy, may receive monthly doses until end date determined by the local State Health Department.**
4. **Synagis® therapy will not be approved with active RSV infection.**
5. **Synagis® prophylaxis will be discontinued if the member is hospitalized for RSV infection while being treated with monthly prophylaxis.**
6. **Synagis® therapy will be provided by the preferred pharmacy vendor.**
7. **Synagis® season information is available on the CDC website:** https://www.cdc.gov/surveillance/nrevss/rsv/state.html

Policy: PHARM-HCU-073
Origination Date: 01/01/2022
Reviewed/Revised Date: 09/18/2024
Next Review Date: 09/18/2025
Current Effective Date: 10/01/2024

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM

ULCERATIVE COLITIS

Avsola®, Entyvio®, Hadlima™, Inflectra®, infliximab, Remicade®, Renflexis®, Rinvoq®, Simlandi®, Simponi®, Skyrizi®, Tremfya®, Xeljanz®, Yesintek™, Zeposia®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department.

- For **Medical Pharmacy** please fax requests to: 801-646-7300
- For **Retail Pharmacy** please fax requests to: 385-425-4052

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-formulary drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred/Non-Preferred/Non-Formulary:

1. **1st Line Preferred Agents:**
   A. Hadlima™ (adalimumab-bwwd), Simlandi® (adalimumab-ryvk)
   B. Infliximab products: Avsola® (infliximab-axxq), Inflectra® (infliximab-dyyb), infliximab, Remicade (infliximab), Renflexis® (infliximab-abda)
   C. Yesintek™ (ustekinumab-kfce)
2. **2nd line preferred agents with single step; after trial and failure of an adalimumab product, an ustekinumab product and an infliximab product:**
   A. Enytvio® (vedolizumab) IV, Xeljanz®/XR (tofacitinib)
3. **Non-Formulary Agents with a triple step; after trial and failure of an adalimumab product, an ustekinumab product, an infliximab product and 2 second line agents:**
   A. Rinvoq® (upadacitinib), Simponi® (golimumab)
4. **Non-Formulary Agent after trial and failure of all the above:**
   A. Entyvio® (vedolizumab) subcutaneous injection, Skyrizi® (risankizumab-rzaa), Tremfya® (guselkumab), Zeposia® (ozanimod)

Product being requested: _____

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
MODERATE TO SEVERE ULCERATIVE COLITIS			
1. Has the member been diagnosed with moderate to severe Ulcerative Colitis?	☐	☐	**Please provide documentation**

2. Is the prescribing provider a gastroenterologist or in consultation with a gastroenterologist?	☐	☐	
3. Has the provider performed tuberculosis (TB) screening prior to therapy initiation?	☐	☐	**Please provide documentation**
4. If the request is for Tumor Necrosis Factor Inhibitors (TNFIs), Rinvoq or Xeljanz/XR, has the provider performed hepatitis B screening prior to therapy initiation?	☐	☐	**Please provide documentation**
5. Has the member had an adequate trial and failure of at least one of the following, or contraindication to all: • High dose oral 5-aminosalicyclic acid drug • Topical 5-aminosalicylic acid drug	☐	☐	**Please provide documentation**
6. If the request is for Rinvoq or Xeljanz/XR®, does documentation show inadequate response or intolerance to at least one tumor necrosis factor (TNF) blocker such as an infliximab product, Cimzia, an adalimumab product and/or Simponi and does documentation show the member will not be receiving Rinvoq or Xeljanz/XR in combination with a potent immunosuppressant (e.g., azathioprine or cyclosporine)?	☐	☐	**Please provide documentation**
SEVERE ULCERATIVE COLITIS			
1. Has the member been diagnosed with severe Ulcerative Colitis? • Has the patient had more than six stools per day with blood OR has systemic symptoms (fever, tachycardia, anemia or erythrocyte sedimentation rate > 30mm/h)?	☐	☐	**Please provide documentation**
2. Is the prescribing provider a gastroenterologist or in consultation with a gastroenterologist?	☐	☐	**Please provide documentation**
3. Has the provider performed tuberculosis (TB) screening prior to therapy initiation?	☐	☐	**Please provide documentation**
4. Has the provider performed hepatitis B screening prior to therapy initiation?	☐	☐	**Please provide documentation**
5. If the request is for Rinvoq or Xeljanz/XR®, does documentation show inadequate response or intolerance to at least one tumor necrosis factor (TNF) blocker such as an infliximab product, Cimzia, Humira and/or Simponi and does documentation show the member will not be receiving Rinvoq or Xeljanz/XR in combination with a potent immunosuppressant (e.g., azathioprine or cyclosporine)?	☐	☐	**Please provide documentation**
FULMINANT COLITIS			
1. Has the member been diagnosed with fulminant colitis? • Has the member had more than 10 bowel movements per day with continuous bleeding OR has colonic dilation, transfusion requirement, or toxicity?	☐	☐	**Please provide documentation**
2. Is the prescribing provider a gastroenterologist or in consultation with a gastroenterologist?	☐	☐	**Please provide documentation**
3. Has the provider performed tuberculosis (TB) screening prior to therapy initiation?	☐	☐	**Please provide documentation**
4. Has the provider performed hepatitis B screening prior to therapy initiation?	☐	☐	**Please provide documentation**
5. If the request is for Rinvoq or Xeljanz/XR®, does documentation show inadequate response or intolerance to at least one tumor necrosis factor (TNF) blocker such as an infliximab product, Cimzia, Humira and/or Simponi and does documentation show the member will not be receiving Rinvoq or Xeljanz/XR in	☐	☐	**Please provide documentation**

combination with a potent immunosuppressant (e.g., azathioprine or cyclosporine)?			
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does updated clinical documentation show a positive response to therapy, such as a decrease or stabilization in the Disease Activity Index (DAI) score?	☐	☐	**Please provide documentation**
3. Has the provider performed continued tuberculosis monitoring during therapy?	☐	☐	**Please provide documentation**
4. Has the provider performed continued Hepatitis B monitoring in HBV carriers?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:

Physician's Signature:

****Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-075
Origination Date: 01/01/2022
Reviewed/Revised Date: 04/09/2025
Next Review Date: 04/09/2026
Current Effective Date: 05/01/2025

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
XOLAIR®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department.

- For **Medical Pharmacy** please fax requests to: 801-646-7300
- For **Retail Pharmacy** please fax requests to: 385-425-4052

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Xolair® (omalizumab)

Dosing/Frequency:_____

Note: for the treatment of nasal polyps see Chronic Rhinosinusitis with Nasal Polyposis (CRSwNP)

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
ASTHMA			
1. Is the prescribing physician an allergist, dermatologist, immunologist, or a pulmonologist?	☐	☐	
2. Has the member shown a positive skin test or in vitro reactivity to a perennial aeroallergen?	☐	☐	**Please provide documentation**
3. Has the member been compliant on a high-dose inhaled corticosteroid with a long-acting inhaled beta-2-agonist for at least 5 months?	☐	☐	
4. Has the member had ≥2 acute exacerbations in a 12-month period requiring additional medical treatment (emergency department visits, hospitalizations, or frequent office visits)?	☐	☐	**Please provide documentation**
5. Does documentation include a current Asthma Control Test ≤19?	☐	☐	**Please provide documentation**
6. Are the member's pre-treatment serum IgE levels ≥30 IU/mL and ≤700 IU/mL?	☐	☐	**Please provide documentation**
7. Does documentation include a predicted FEV1 or PEF?	☐	☐	**Please provide documentation**
CHRONIC IDOPATHIC URTICARIA (CIU)			
1. Has the provider performed a medical evaluation that rules out other possible causes of urticaria?	☐	☐	**Please provide documentation**

2. Has the member had a trial and failure of an H1-antihistamine used in combination with an H2-antihistamine?	☐	☐	**Please provide documentation**
3. Has the member had a trial and failure of an H1-antihistamine used in combination with a leukotriene receptor antagonist or cyclosporine?	☐	☐	**Please provide documentation**
4. Is the request for dose escalation of Xolair?	☐	☐	
IgE-Mediated Food Allergy			
1. Is the prescribing physician an allergist or immunologist?	☐	☐	
2. Is the member aged between 1 and 17 years old?	☐	☐	
3. Is baseline immunoglobulin (Ig)E level ≥ 30 IU/mL?	☐	☐	**Please provide documentation**
4. Does documentation show that the member has experienced dose-limiting symptoms (e.g. moderate to severe skin, respiratory, or GI symptoms) to a single dose of ≤100 mg of peanut protein, or ≤300 mg protein for each of 2 of the following other 6 foods: milk, egg, wheat, cashew, hazelnut, or walnut?	☐	☐	**Please provide documentation**
5. Does documentation show a positive skin test (≥4 mm wheal greater than saline control) AND in vitro reactivity (IgE ≥6 kUA/L) to peanut, or at least two of the following 6 other foods: milk, egg, wheat, cashew, hazelnut, walnut?	☐	☐	**Please provide documentation**
6. Does member have an active prescription for an EpiPen?	☐	☐	
7. Does documentation show that Xolair will be used in conjunction with a diet that avoids food allergens?	☐	☐	
8. Does member have a history of severe anaphylaxis, eosinophilic esophagitis, poorly controlled atopic dermatitis, or poorly controlled asthma?	☐	☐	
9. Does documentation show that Xolair® will NOT be used in combination with other monoclonal antibody therapy, such as Dupixent® (dupilumab), Fasenra™ (benralizumab), Nucala® (mepolizumab), and/or Cinqair® (reslizumab)?	☐	☐	
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does clinical documentation show continued medical necessity and that the treatment has stabilized or improved the member's condition?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:

Physician's Signature:

****Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-079
Origination Date: 01/01/2022
Reviewed/Revised Date: 05/22/2024
Next Review Date: 05/22/2025
Current Effective Date: 06/01/2024

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
PANCREATIC ENZYMES
Creon®, Viokace®, Pancreaze®, Pertzye®, Zenpep®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred: ☐ Creon® (pancrelipase), ☐ Zenpep® (pancrelipase)
Non-preferred: ☐ Viokace® (pancrelipase), ☐ Pancreaze® (pancrelipase), ☐ Pertzye® (pancrelipase)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Does the member have exocrine pancreatic insufficiency caused by cystic fibrosis (CF)?	☐	☐	**Please provide documentation**
2. Does the member have exocrine pancreatic insufficiency due to pancreatectomy (including Whipple procedure)?	☐	☐	**Please provide documentation**
3. Does the member have exocrine pancreatic insufficiency due to chronic pancreatitis or other conditions (including type 1 diabetes mellitus) and one of the following: • Fecal elastase-1 <200mcg • Fecal elastase-1 <250mcg/g on two distinct tests • Peak bicarbonate concentration <80mEq/L (from a direct pancreas function testing with an endoscopic secretin test (one-hour method)	☐	☐	**Please provide documentation**
4. If the member has pancreatic insufficiency due to excessive alcohol consumption, has the following been documented: • Alcohol cessation counseling • Offer to enroll in an alcohol abuse program	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	

2. Has the member's therapy been re-evaluated within the past 12 months?	☐	☐	
3. Has the therapy shown to be effective with an improvement in condition?	☐	☐	**Please provide documentation**
4. Does the member show a continued need for the therapy?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request ****

Policy PHARM-HCU-080
Origination Date: 01/01/2022
Reviewed/Revised Date: 11/13/2024
Next Review Date: 11/13/2025
Current Effective Date: 12/01/2024

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
BENLYSTA®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department.

- For **Medical Pharmacy** please fax requests to: 801-646-7300
- For **Retail Pharmacy** please fax requests to: 385-425-4052

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Benlysta® (belimumab)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
SYSTEMIC LUPUS ERYTHEMATOSUS			
1. Does the member have a confirmed diagnosis of active moderate to severe systemic lupus erythematosus?	☐	☐	**Please provide documentation**
2. Is the request made by, or in consultation with, a rheumatologist?	☐	☐	
3. Does the member have a Safety of Estrogen in Lupus National Assessment-Systemic Lupus Erythematosus Disease Activity Index (SELENA-SLEDAI) score of ≥ 6?	☐	☐	**Please provide documentation**
4. Does the member have active musculoskeletal or cutaneous disease that is unresponsive to standard therapy with glucocorticoids and/or other immunosuppressive agents?	☐	☐	**Please provide documentation**
5. Is there documentation of corticosteroid-dependent disease (prednisone equivalent dose ≥10mg/day) OR trial and failure of both hydroxychloroquine AND at least 1 immunosuppressant (e.g., azathioprine, methotrexate, mycophenolate)?	☐	☐	**Please provide documentation**
6. Has the member been at least 80% compliant for at least 6 months with their baseline therapy (i.e., steroids and/or immunosuppressants)?	☐	☐	**Please provide documentation**
7. Will Benlysta® be used concurrently with baseline therapy?	☐	☐	**Please provide documentation**

8. Does the member have documentation of active central nervous system lupus (e.g. generalized seizures, psychosis, stroke, peripheral neuropathies)?	☐	☐	**Please provide documentation**
9. Has the member received any other biologics, immunoglobulins, IV cyclophosphamide, or prednisone >100mg daily within the last 6 months?	☐	☐	**Please provide documentation**
LUPUS NEPHRITIS			
1. Does the member have a confirmed diagnosis of lupus nephritis?	☐	☐	**Please provide documentation**
2. Is the request made by, or in consultation with, a nephrologist or rheumatologist?	☐	☐	
3. Did the member have a kidney biopsy showing a histological diagnosis of lupus nephritis Class III, IV or V?	☐	☐	**Please provide documentation**
4. Does documentation show a recent eGFR ≥ 30 mL/min/1.73m^2?	☐	☐	**Please provide documentation**
5. Has the member had dialysis in the past 12 months?	☐	☐	
6. Is the member currently receiving standard immunosuppressive therapy for systemic lupus erythematosus?	☐	☐	**Please provide documentation**
7. Will Benlysta® be used concurrently with baseline therapy?	☐	☐	**Please provide documentation**
8. Does the member have active central nervous system lupus (e.g. generalized seizures, psychosis, stroke, peripheral neuropathies)?	☐	☐	**Please provide documentation**
9. Has the member received any other biologics, immunoglobulins, IV cyclophosphamide, or prednisone >100mg daily within the last 6 months?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
SYSTEMIC LUPUS ERYTHEMATOSUS			
1. Is the request for reauthorization of therapy for systemic lupus erythematosus?	☐	☐	
2. Does clinical documentation show continued medical necessity, as well as efficacy and tolerability of therapy?	☐	☐	**Please provide documentation**
3. Does documentation show continued use of baseline therapy?	☐	☐	**Please provide documentation**
LUPUS NEPHRITIS			
1. Is the request for reauthorization of therapy for lupus nephritis?	☐	☐	
2. Has the member had an improvement in organ dysfunction, reduction in flares, reduction in corticosteroid dose, decrease of anti-dsDNA titer and/or improvement in complement levels?	☐	☐	**Please provide documentation**
3. Does documentation show continued use of standard therapy during Benlysta® administration?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			

Additional information:
Physician Signature:

****Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-081
Origination Date: 01/01/2022
Reviewed/Revised Date: 09/18/2024
Next Review Date: 09/18/2025
Current Effective Date: 10/01/2024

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
IRON CHELATION THERAPY
deferasirox (Exjade®, Jadenu®), Jadenu®, Ferriprox®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department.

- For **Medical Pharmacy** please fax requests to: 801-646-7300
- For **Retail Pharmacy** please fax requests to: 385-425-4052

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred: ☐ deferoxamine solution for injection, ☐ deferasirox tablets, ☐ deferasirox dispersible tablets
Non-preferred: ☐ Ferriprox® tablets and solution (deferiprone), ☐ deferasirox granules, oral packet

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.			
Questions	**Yes**	**No**	**Comments/Notes**
1. Does the member have a diagnosis that is approved by the US Food and Drug Administration?	☐	☐	**Please provide documentation**
2. Is the prescriber a hematologist, or in consultation with one?	☐	☐	
DEFERASIROX TABLETS			
1. Does the member have an eGFR <40mL/min/1.73^2 and/or platelet counts <50x10^9/L?	☐	☐	**Please provide documentation**
2. Is the request for the indication of chronic iron overload due to blood transfusions? If NO, go to # 6.	☐	☐	
3. Does the member have a history of receiving blood transfusions totaling ≥100mL/kg of packed red blood cells?	☐	☐	**Please provide documentation**
4. Does the member have a serum ferritin ≥1000ng/mL before initiation of therapy on at least 2 consecutive measurements taken at least 1 month apart?	☐	☐	**Please provide documentation**
5. Does the member have a liver iron concentration ≥5mg Fe/g dry weight determined by a liver biopsy, T2* MRI, or FerriScan?	☐	☐	**Please provide documentation**
6. Is the request for the indication of chronic iron overload with transfusion-independent thalassemia (non-transfusion-dependent thalassemia) syndromes?	☐	☐	

7. Is the member 10 years of age or older?	☐	☐	
8. Does the member have a liver iron concentration ≥5mg Fe/g dry weight determined by a liver biopsy, T2* MRI, or FerriScan?	☐	☐	**Please provide documentation**
9. Does the member have a serum ferritin ≥300ng/mL on at least 2 consecutive measurements taken at least 1 month apart?	☐	☐	**Please provide documentation**
FERRIPROX®			
1. Does the member have a diagnosis of transfusion-dependent iron overload due to thalassemia syndromes?	☐	☐	**Please provide documentation**
2. Has the member had an adequate trial and failure or contraindication/intolerance to deferasirox or deferoxamine?	☐	☐	**Please provide documentation**
3. Is the member's initial absolute neutrophil count (ANC) ≥1.5x10^9/L?	☐	☐	**Please provide documentation**
4. Does the physician agree to monitor ANC levels while on therapy and to interrupt therapy if neutropenia or signs of infection develop?	☐	☐	
5. Does the member have a transfusion history of ≥100mL/kg of packed red blood cells and a serum ferritin level ≥1,000ng/mL?	☐	☐	**Please provide documentation**
6. Does the member have a liver iron concentration<7mg Fe/g dry weight determined by a liver biopsy, T2* MRI, FerriScan?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Is the member's current liver iron concentration < 3 mg Fe/g dry weight determined by a liver biopsy, T2* MRI, or FerriScan or ferritin is ≤ 300ng/mL?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request. ****

Policy: PHARM-HCU-082
Origination Date: 01/01/2022
Reviewed/Revised Date: 03/18/2025
Next Review Date: 03/18/2026
Current Effective Date: 04/01/2025

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
NUEDEXTA®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Nuedexta® (dextromethorphan 20mg and quinidine 10mg)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Is the member 18 years of age or older?	☐	☐	
2. Is the requesting provider a neurologist?	☐	☐	
3. Does the member have a documented diagnosis of pseudobulbar affect (PBA) secondary to at least one of the following: • Amyotrophic lateral sclerosis • Multiple sclerosis • Ischemic or hemorrhagic stroke • Traumatic brain injury • Dementia – including Alzheimer's disease, Vascular, Lewy body, or Frontotemporal Dementia	☐	☐	**Please provide documentation**
4. Has the underlying condition been stable for at least the past 2 months?	☐	☐	**Please provide documentation**
5. Is there documentation of a baseline Center for Neurologic Studies Lability Score (CNS-LS)?	☐	☐	**Please provide documentation**
6. Does the member show clinical symptoms of episodes of sudden uncontrollable and inappropriate laughing or crying?	☐	☐	**Please provide documentation**
7. Is the member's baseline PBA score ≥ 13?	☐	☐	**Please provide documentation**
8. Have the member's number of PBA episodes per day been documented?	☐	☐	**Please provide documentation**

9. Has the member had a 3-month trial and failure of, or contraindication to, both of the following medication classes: • tricyclic antidepressant (TCA) • selective serotonin reuptake inhibitor (SSRI)	☐	☐	**Please provide documentation**
10. Does documentation show a baseline EKG with any significant abnormalities and/or does the member have a history of QT prolongation syndrome?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member's therapy been re-evaluated within the past 12 weeks with a neurologist?	☐	☐	
3. Has the requesting provider evaluated for a spontaneous improvement of PBA prior to this renewal request?	☐	☐	**Please provide documentation**
4. Does the requesting prescriber agree to re-evaluate EKG if risk factors change during the course of treatment?	☐	☐	
5. Has the member shown a decrease in CNS-LS score?	☐	☐	**Please provide documentation**
6. Has the member shown at least a 30% improvement in the number of PBA episode per day from baseline?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy PHARM-HCU-083
Origination Date: 01/01/2022
Reviewed/Revised Date: 05/27/2025
Next Review Date: 05/27/2026
Current Effective Date: 06/01/2025

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
XHANCE®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred: ☐ fluticasone propionate nasal spray ☐ mometasone nasal spray
Non-preferred: ☐ Xhance® (fluticasone propionate)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Does the member have a diagnosis of chronic rhinosinusitis with nasal polyposis (CRSwNP) or chronic rhinosinusitis without nasal polyposis?	☐	☐	**Please provide documentation**
2. Is the request being made by or in consultation with an allergist, ENT specialist, or pulmonologist?	☐	☐	
3. Is the member at 18 years of age or older?	☐	☐	
4. Does documentation show a 3-month trial and failure of or contraindication/intolerance to BOTH of the following intranasal steroids? • fluticasone propionate 50 mcg/actuation nasal spray • mometasone furoate 50 mcg/actuation nasal spray	☐	☐	**Please provide documentation**
5. For chronic rhinosinusitis **with nasal polyposis (CRSwNP):** Does documentation show diagnosis confirmed by one of the following: • Anterior rhinoscopy • Nasal endoscopy • Computed tomography (CT)	☐	☐	**Please provide documentation**

6. For chronic rhinosinusitis **without** nasal polyposis: Does documentation show the member has at least two of four cardinal symptoms: nasal obstruction, anterior or posterior nasal discharge, reduction or loss of smell, and facial pain/pressure/fullness for at least 12 weeks duration?	☐	☐	**Please provide documentation**
7. For chronic rhinosinusitis **without** nasal polyposis: Does documentation include objective evidence of mucosal inflammation, either by direct visualization or on an imaging study (sinus computed tomography [CT] scan)?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the requesting for reauthorization of therapy?	☐	☐	
2. Has the member's therapy been re-evaluated within the past 6 months?	☐	☐	
3. Has the therapy shown to be effective with an improvement in condition?	☐	☐	**Please provide documentation**
4. Does the member show a continued medical need for the therapy?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-086
Origination Date: 01/01/2022
Reviewed/Revised Date: 05/27/2025
Next Review Date: 05/27/2026
Current Effective Date: 06/01/2025

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
YUPELRI®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Yupelri® (revefenacin)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Is the member 18 years of age or older?	☐	☐	
2. Is the requesting provider a pulmonologist or in consultation with a pulmonologist?	☐	☐	
3. Has the member been diagnosed with moderate to severe COPD (i.e. COPD GOLD stage II, III, IV)?	☐	☐	**Please provide documentation**
4. Does documentation indicate the member is a non-smoker or smoking cessation has been addressed?	☐	☐	**Please provide documentation**
5. Does the member have a cognitive or physical impairment that limits their ability to use a metered dose inhaler (MDI) or dry powder inhaler (DPI)?	☐	☐	**Please provide documentation**
6. Is the member unable to generate adequate inspiratory force to use a dry powder inhaler (e.g. peak inspiratory flow rate (PIFR) <60L/min)?	☐	☐	**Please provide documentation**
7. Has the member tried at least 2 of the following preferred medications for at least 3 months with an inadequate response: • Ipratropium bromide solution for nebulizer • Incruse® Ellipta® (umedclidinium) • Spiriva® Handihaler® (tiotropium) • Spiriva® Respimat® (tiotropium)	☐	☐	**Please provide documentation**

8. Was the member unable to try two of the preferred medications listed in question 7 due to a medical reason?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member's therapy been re-evaluated within the past 12 months?	☐	☐	
3. Has the member had a reduction in symptoms?	☐	☐	**Please provide documentation**
4. Has the member had a reduction symptoms and in the number and frequency of exacerbations?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy PHARM-HcU-087
Origination Date: 01/01/2022
Reviewed/Revised Date: 04/09/2025
Next Review Date: 04/09/2026
Current Effective Date: 05/01/2025

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM

ACUTE MIGRAINE

D.H.E 45®, Migranal®, Nurtec™, Reyvow™, Treximet®, Ubrelvy®, Zavzpret™

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested:
Preferred: ☐ generic triptan medications (e.g., almotriptan, sumatriptan, rizatriptan), ☐ Ubrelvy® (ubrogepant)
Non-Preferred: ☐ Nurtec™ (rimegepant)
Non-Formulary: ☐ dihydroergotamine mesylate injection, ☐ dihydroergotamine mesylate nasal spray, ODT, ☐ Reyvow™ (lasmmiditan), ☐ Treximet® (sumatriptan and naproxen sodium) ☐ Zavzpret™ (zavegepant) nasal spray

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Is the request made by, or in consultation with, a neurologist or headache specialist?	☐	☐	
2. Does the member have a documented diagnosis of migraine with or without aura?	☐	☐	**Please provide documentation**
3. Does clinical documentation show either: • Member has less than 15 headache days per month? • Member has ≥ 15 headache days per month AND taking a prophylactic agent (e.g. an antidepressant, anticonvulsant, beta-blocker, Botox®, or calcium channel blocker)?	☐	☐	**Please provide documentation**
4. Has the member had a trial and failure or contraindication/intolerance to at least two preferred generic triptan medications taken at the maximum FDA-approved dosage in both an oral formulation AND either a nasal spray or subcutaneous injection? (e.g. sumatriptan, rizatriptan, zolitriptan)?	☐	☐	**Please provide documentation**
5. For non-preferred medications, has the member had a trial and failure of Ubrelvy®?	☐	☐	**Please provide documentation**

6. Is the member taking a Calcitonin Gene-Related Peptide (CGRP) medication to prevent migraine headaches?	☐	☐	**Please provide documentation**
DIHYDROERGOTAMINE MESYLATE NASAL SPRAY			
1. Has the member had a trial and failure, or intolerance, to dihydroergotamine injection?	☐	☐	**Please provide documentation**
TREXIMET			
1. Has the member tried and found to be intolerant to the inactive ingredients in both naproxen sodium and sumatriptan?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does documentation show the member has a positive clinical response to therapy?	☐	☐	**Please provide documentation**
3. Is the member taking a Calcitonin Gene-Related Peptide (CGRP) medication to prevent migraine headaches?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request ****

Policy PHARM-HCU-088
Origination Date: 01/01/2022
Reviewed/Revised Date: 03/27/2024
Next Review Date: 03/27/2025
Current Effective Date: 04/01/2024

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM

PARKINSON'S AGENTS

Apomorphine hydrochloride injection, Duopa™, Neupro®, Nourianz™, Ongentys®, Rytary®, Tasmar®, tolcapone, Zelapar®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ apomorphine hydrochloride injection, ☐ Duopa™ (levodopa/carbidopa enteral suspension), ☐ Neupro® (rotigotine patch), ☐ Nourianz™ (istradefylline), ☐ Ongentys® (opicapone), ☐ Rytary® (carbidopa/levodopa extended release), ☐ tolcapone, ☐ Zelapar® (selegiline hydrochloride ODT)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.			
Questions	**Yes**	**No**	**Comments/Notes**
1. Does the member have a diagnosis of Parkinson's disease?	☐	☐	**Please provide documentation**
2. Is the prescriber a neurologist?	☐	☐	
3. Has the member had an inadequate response to oral levodopa/carbidopa therapy?	☐	☐	**Please provide documentation**
APOMORPHINE HYDROCHLORIDE INJECTION			
1. Is the request for apomorphine hydrochloride injection?	☐	☐	
2. Will the member be concurrently taking levodopa/carbidopa with apomorphine hydrochloride injection therapy?	☐	☐	
3. Is the member experiencing "off" episodes ("end-of-dose wearing off" and unpredictable "on/off" episodes) associated with advanced Parkinson's disease?	☐	☐	**Please provide documentation**
4. Has the member had a trial and failure or contraindication/intolerance to a preferred dopamine agonist (pramipexole, ropinirole), COMT inhibitor (entacapone), or MAO-B inhibitor (selegiline)?	☐	☐	**Please provide documentation**
5. Will the member be taking a 5HT3 antagonist concurrently with apomorphine hydrochloride injection?	☐	☐	

DUOPA™			
1. Is the request for Duopa™?	☐	☐	
2. Is the member responsive to levodopa with defined "on" periods?	☐	☐	**Please provide documentation**
3. Is the member experiencing ≥3 hours of "off" episodes despite maximally tolerated levodopa/carbidopa and one other class of anti-Parkinson's disease therapy (dopamine agonist, pramipexole or ropinirole), COMT inhibitor (entacapone), or MAO-B inhibitor (selegiline)?	☐	☐	**Please provide documentation**
4. Has the member undergone or has a planned placement of a PEG-J tube?	☐	☐	
NEUPRO®			
1. Is the request for Neupro®?	☐	☐	
2. Is the member unable to take medications by mouth or is oral therapy clinically inappropriate?	☐	☐	**Please provide documentation**
3. Has the member had a trial and failure or contraindication/intolerance to at least two of the following, one of which must be an extended release product: ropinirole, pramipexole, bromocriptine?	☐	☐	**Please provide documentation**
NOURIANZ™			
1. Is the request for Nourianz™?	☐	☐	
2. Will the member be concurrently taking levodopa/carbidopa with Nourianz™ therapy?	☐	☐	
3. Is the member experiencing ≥2 hours of "off" episodes associated with advanced Parkinson's disease despite maximally tolerated levodopa/carbidopa and two other classes of anti-Parkinson's disease therapy (dopamine agonist, pramipexole or ropinirole), COMT inhibitor (entacapone), or MAO-B inhibitor (selegiline)?	☐	☐	**Please provide documentation**
ONGENTYS®			
1. Is the request for Ongentys®?	☐	☐	
2. Will the member be concurrently taking levodopa/carbidopa with Ongentys® therapy?	☐	☐	
3. Is the member experiencing ≥2 hours of "off" episodes associated with advanced Parkinson's disease despite maximally tolerated levodopa/carbidopa and two other classes of anti-Parkinson's disease therapy (dopamine agonist, pramipexole or ropinirole), COMT inhibitor (entacapone), or MAO-B inhibitor (selegiline)?	☐	☐	**Please provide documentation**
RYTARY®			
1. Is the request for Rytary®?	☐	☐	
2. Has the member had at least a 3-month trial and failure or contraindication to generic extended-release carbidopa/levodopa?	☐	☐	**Please provide documentation**
TOLCAPONE			
1. Is the request for tolcapone generic tablets?	☐	☐	
2. Has the member had a 3-month trial and failure or contraindication/intolerance to entacapone or levodopa/carbidopa/entacapone?	☐	☐	**Please provide documentation**
3. Will the member be concurrently taking levodopa/carbidopa with tolcapone therapy?	☐	☐	

ZELAPAR®			
1. Is the request for Zelapar®?	☐	☐	
2. Has the member exhibited deterioration in the quality of their response to levodopa/carbidopa?	☐	☐	**Please provide documentation**
3. Has the member had a trial and failure or contraindication/ intolerance to conventional selegiline tablets?	☐	☐	**Please provide documentation**
4. Will the member be concurrently taking levodopa/carbidopa with Zelapar® therapy?	☐	☐	
REAUTHORIZATION			
1. Is the requesting for reauthorization of therapy?	☐	☐	
2. Has the therapy shown to be effective with a positive clinical response?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-089
Origination Date: 01/01/2022
Reviewed/Revised Date: 09/18/2024
Next Review Date: 09/18/2025
Current Effective Date: 10/01/2024

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
ICOSAPENT ETHYL

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Vascepa® (icosapent ethyl)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
HYPERTRIGLYCERIDEMIA			
1. Does the member have a diagnosis of severe hypertriglyceridemia with triglyceride (TG) level >500mg/dL?	☐	☐	**Please provide documentation**
2. Does the prescriber attest that the member is on appropriate lipid lowering diet and exercise regimen?	☐	☐	
3. Has the member had a 3-month trial and failure or contraindication to a fibrate (fenofibrate, gemfibrozil) and a preferred generic omega-3-acid ethyl ester?	☐	☐	**Please provide documentation**
CARDIOVASCULAR RISK REDUCTION WITH MILD HYPERTRIGLYCERIDEMIA			
1. Is the member >45 years of age with an established cardiovascular disease (e.g. coronary artery disease, cerebrovascular, carotid artery, or peripheral artery disease)?	☐	☐	**Please provide documentation**
2. Is the member >50 years of age with diabetes (A1c <10.0%) in combination with at least one of the following additional risk factor for cardiovascular disease: • Retinopathy • Microalbuminuria or macroalbuminuria • Renal dysfunction (CrCl <60mL/min) • Hypertension (BP ≥140/90mmHg) • Men ≥55 years of age or women ≥65 years of age • HDL ≤40mg/dL for men or ≤50mg/dL for women • ABI <0.9	☐	☐	**Please provide documentation**

3. Does the member have a history of NYHA class IV heart failure?	☐	☐	
4. Does the member have a history of severe liver disease?	☐	☐	
5. Does the prescriber attest that the member is on appropriate lipid lowering diet and exercise regimen?	☐	☐	
6. Is the member currently taking a moderate to high intensity statin?	☐	☐	**Please provide documentation**
7. Will the moderate to high intensity statin be continued in combination with Vascepa®?	☐	☐	**Please provide documentation**
8. Does documentation show triglyceride level of 135 to 499mg/dL and LDL level of 40 to 100mg/dL?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the therapy shown to be effective with an improvement in condition?	☐	☐	**Please provide documentation**
3. Does the member show a continued medical need for the therapy?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request ****

Policy: PHARM-HCU-090
Origination Date: 01/01/2022
Reviewed/Revised Date: 12/30/2024
Next Review Date: 12/30/2025
Current Effective Date: 01/01/2025

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
OFEV®, pirfenidone

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ pirfenidone*, ☐ Ofev® (nintedanib)
*does not require prior authorization

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.			
Questions	**Yes**	**No**	**Comments/Notes**
1. Does the member have one of the corresponding diagnoses: • pirfenidone: idiopathic pulmonary fibrosis • Ofev: chronic fibrosing interstitial lung disease with a progressive phenotype, idiopathic pulmonary fibrosis, or systemic sclerosis-associated interstitial lung disease?	☐	☐	**Please provide documentation**
2. Is the requesting prescriber a pulmonologist or in consultation with a pulmonologist?	☐	☐	
3. Does the member have a forced vital capacity (%FVC) of > 50% predicted?	☐	☐	**Please provide documentation**
4. Does the member have a carbon monoxide diffusing capacity (%DLco) of 30-90% predicted?	☐	☐	**Please provide documentation**
5. Have recent liver function tests been performed?	☐	☐	**Please provide documentation**
6. Is the member's diagnosis confirmed by high-resolution computed tomography (HRCT) scan, a bronchioaveolar lavage (BAL) and/or a surgical lung biopsy?	☐	☐	**Please provide documentation**
7. For the request of Ofev for idiopathic pulmonary fibrosis, has the member tried pirfenidone? Pirfenidone dose not require prior authorization	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	

2. Does the member show a continued medical need and tolerability of the therapy?	☐	☐	**Please provide documentation**
3. Does documentation show current liver enzymes are within normal limits?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:

Physician Signature:

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-091
Origination Date: 01/01/2022
Reviewed/Revised Date: 12/30/2024
Next Review Date: 12/30/2025
Current Effective Date: 01/01/2025

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
CABLIVI®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department.

- For **Medical Pharmacy** please fax requests to: 801-646-7300
- For **Retail Pharmacy** please fax requests to: 385-425-4052

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Cablivi® (caplacizumab-yhdp)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.			
Questions	**Yes**	**No**	**Comments/Notes**
1. Does the member have a diagnosis of acquired thrombotic thrombocytopenia purpura (aTTP) with ADAMTS13 activity <10%?	☐	☐	**Please provide documentation**
2. Is the prescriber a hematologist or in consultation with one?	☐	☐	
3. Is the member 18 years of age or older?	☐	☐	
4. Will Cablivi® be started in a hospital setting in combination with plasma exchange?	☐	☐	**Please provide documentation**
5. Will Cablivi® be used in combination with immunosuppressive therapy (e.g. corticosteroids, rituximab)?	☐	☐	**Please provide documentation**
6. Have secondary causes of thrombocytopenia been ruled out (e.g. congenital thrombotic thrombocytopenia purpura, hemolytic uremic syndrome, drug-induced thrombocytopenia)?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does documentation show persistent underlying disease with an ADAMTS13 activity <20%?	☐	☐	**Please provide documentation**
3. Has the member experienced >2 recurrences of aTTP during initial therapy?	☐	☐	
4. Has the member demonstrated a positive response to therapy shown by one of the following:	☐	☐	**Please provide documentation**

• Clinically significant increase in platelet count (i.e. platelet count is within the normal range) • Reduction in neurological symptoms • Improvement in organ-damage markers (lactate dehydrogenase, cardiac troponin1 and serum creatinine)			

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.
Additional information:
Physician Signature:

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request ****

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
NEXLETOL®, NEXLIZET™

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Nexletol® (bempedoic acid), ☐ Nexlizet™ (bempedoic acid/ezetimibe)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Does the member have a documented diagnosis of heterozygous familial hypercholesterolemia or established atherosclerotic cardiovascular disease?	☐	☐	**Please provide documentation**
2. Has the member demonstrated at least 80% compliance with high intensity statin therapy or contraindication/intolerance to at least four generic statin therapies?	☐	☐	**Please provide documentation**
3. Is the member's fasting LDL-C level > 70mg/dL?	☐	☐	**Please provide documentation**
4. Is the member taking a proprotein convertase substilisin/kexin 9 (PCSK9) inhibitor?	☐	☐	
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does documentation show a decrease in baseline LDL-C level of at least 15% from baseline?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:
Physician Signature:

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request ****

Policy: PHARM-HCU-099
Origination Date: 01/01/2022
Reviewed/Revised Date: 11/13/2024
Next Review Date: 11/13/2025
Current Effective Date: 12/01/2024

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
PREVYMIS™

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department.

- For **Medical Pharmacy** please fax requests to: 801-646-7300
- For **Retail Pharmacy** please fax requests to: 385-425-4052

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Prevymis™ (letermovir)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
Prophylaxis of CMV infection and disease in allogeneic hematopoietic stem cell transplant recipients			
1. Is the requesting provider an infectious disease specialist, hematologist, oncologist, or transplant specialist?	☐	☐	
2. Does documentation show the member is cytomegalovirus (CMV)-seropositive [R+]?	☐	☐	**Please provide documentation**
3. Is the member an allogeneic hematopoietic stem cell transplant recipient?	☐	☐	**Please provide documentation**
4. Is the therapy initiated between day 0 and day 28 post-transplant?	☐	☐	**Please provide documentation**
5. Does the member have severe (Child-Pugh C) hepatic impairment?	☐	☐	**Please provide documentation**
Prophylaxis of CMV infection and disease in kidney transplant recipients at high risk			
1. Is the requesting provider an infectious disease specialist, hematologist, oncologist, or transplant specialist?	☐	☐	
2. Does documentation show the donor is cytomegalovirus (CMV) seropositive [D+]?	☐	☐	**Please provide documentation**
3. Does documentation show the member (recipient) is CMV seronegative [R-]?	☐	☐	**Please provide documentation**
4. Is the member a kidney transplant recipient?	☐	☐	**Please provide documentation**

5. Does the patient have valganciclovir and ganciclovir?	☐	☐	**Please provide documentation**
6. Is the therapy initiated between day 0 and day 7 post-transplant?	☐	☐	**Please provide documentation**
7. Does the member have severe (Child-Pugh C) hepatic impairment?	☐	☐	**Please provide documentation**
INJECTABLE PREVYMIS™			
1. Is the member unable to swallow or has severe dysphagia preventing the use of solid oral medication?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request ****

Policy: PHARM-HCU-100
Origination Date: 01/01/2022
Reviewed/Revised Date: 09/18/2024
Next Review Date: 09/18/2025
Current Effective Date: 10/01/2024

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM

UVEITIS

Hadlima™, Humira®, Simlandi®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred/Non-Formulary:

1. **1st Line Preferred Agents:**
   A. Hadlima™ (adalimumab-bwwd), Simlandi® (adalimumab-ryvk)
2. **2nd line preferred agents with single step; after trial and failure of Hadlima or Simlandi:**
   A. Humira® (adalimumab)

Product being requested: _____

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.			
Questions	**Yes**	**No**	**Comments/Notes**
1. Is the member 2 years of age or older?	☐	☐	
2. Is the requesting provider an ophthalmologist or in consultation with one?	☐	☐	
3. Has the member been diagnosed with non-infectious uveitis classified as intermediate, posterior, or panuveitis?	☐	☐	**Please provide documentation**
4. Has the member had a trial and failure of at least one systemic corticosteroid at the maximum indicated dose within the past 3 months?	☐	☐	**Please provide documentation**
5. Has the member had a trial and failure of at least one systemic non-biologic immunosuppressant (methotrexate, cyclosporine, azathioprine, mycophenolate, etc.) within the last 3 months?	☐	☐	**Please provide documentation**
6. Will Hadlima, Humira, or Simlandi be used in combination with any other biologic or small molecule DMARD (Xeljianz, Otezla, etc.)?	☐	☐	
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	

2. Does documentation show a positive clinical response to treatment?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-101
Origination Date: 01/01/2022
Reviewed/Revised Date: 12/24/2024
Next Review Date: 12/24/2024
Current Effective Date: 01/01/2025

Pharmacy Continuity of Care

Policy: PHARM-HCU-103

Origination Date: 01/01/2022

Reviewed/Revised Date: 07/29/2024

Next Review Date: 07/29/2025

Current Effective Date: 08/01/2024

Disclaimer:

1. Policies are subject to change in accordance with Federal and State notice requirements.
2. Policies outline coverage determinations for Health Choice Utah (Medicaid). Refer to the "Policy" and "Lines of Business" section for more information.
3. Services requiring prior-authorization may not be covered, if the prior-authorization is not obtained.
4. This Pharmacy Policy does not guarantee coverage or payment of the service. The service must be a benefit in the member's plan and the member must be eligible for coverage at the time of service. Additional payment guidelines may be applied that are not included in this policy.

Purpose

To define and provide guidance for circumstances under which the Health Choice Utah Medicaid (HCU) will allow continuity of care and offer coverage for a supply of a medication for new members within the first 90 days of enrollment when the medication is not covered on the formulary or if it has coverage restrictions.

Definitions

1. Exception Request: a process used by HCU to enable a member or provider to request an exception to the formulary or pharmacy benefit.
2. Medically Necessary: therapy that a prescribing healthcare provider can justify as reasonable, necessary, and/or appropriate to treat specific diagnoses for injury, diseases, and their associated symptoms, based on evidence-based clinical standards of care.
    A. Not mainly for convenience of the member, that of the provider, or other health care provider; and
    B. Not more costly than an alternative drug, service(s), or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of illness, injury, disease, or symptoms
3. Non-formulary Therapy: a drug or product not listed on the HCU Formulary and not covered by the pharmacy benefit unless a formulary exception is approved by the Plan.
4. Orphan Drug: a medication used to treat, prevent or diagnose an orphan disease as defined by the U.S. Food and Drug Administration (FDA).

5. Preferred Drug List (PDL) or Formulary: a list of medications that are covered by the HCU pharmacy benefit.
6. Prior Authorization (PA): a process used by HCU to assure drug benefits are administered as designed, that members receive medications that are safe and effective for the condition being treated, and that the medications used have the greatest value. Prior Authorizations require the prescriber to receive pre-approval for coverage of a particular medication in order for the drug to be covered by the HCU benefit.
7. Quantity Limits (QL): a limitation that is placed on daily dose, days' supply, or maximum quantity of a drug over a defined period of time. Quantity limits help assure FDA-approved doses or durations are not exceeded for the safety of the member. Exceptions may be considered when the benefits outweigh the risks to the member.
8. Step Therapy (ST): a process designed to assure that first line drugs, which have been proven to be safe and effective and that demonstrate greater value, are used before second line and potentially more costly alternatives are considered. Most brand medications with generic alternatives require ST through the generic product before the brand may be considered for authorization.

Policy/Coverage

1. Coverage Criteria

A. During the first 90 days of enrollment, HCU may cover transition fills of a non-formulary drug, as well as drugs with restrictions or limits.

B. This transition supply is intended for the member's immediate needs to be met, while allowing enough time to work with the provider to prescribe a medication that is on the preferred drug list or to submit a prior authorization request.

C. Transition fills will not exceed a 90 day supply.

D. New members are <u>not</u> eligible for a transition fill of a non-formulary or restricted medication if ALL of the circumstances are met:

   i. There are alternative agents on formulary with a same or similar mechanism of action

   ii. The change to a new agent does not require a provider visit

   iii. Member's disease state is stable or not so fragile that transition to a formulary or preferred agent will not cause the member to experience serious clinical complications.

E. New members may be eligible for up to 90 days coverage of a non-formulary or restricted medication while the member is transitioning to formulary/preferred agents if ALL the following are met:

   i. A change to an alternative therapy requires one of the following:

      a. A visit or consultation with a new or specialty provider

      b. The condition being treated is an 'orphan' condition as defined by Orphanet or the National Organization for Rare Disorders (NORD)

ii. Treatment is a recognized treatment option supported by medical literature and/or NORD
iii. There are no alternative therapies with the same mechanism of action on the formulary, but there are drugs on formulary that are acceptable alternatives to treat the condition
iv. Discontinuation of the agent WILL likely cause serious harm to member resulting in hospitalization, use of other health resources or death

F. Members may be eligible for full coverage for up to 12 months when all of the following are met:
    i. The provider has submitted a prior authorization (formulary medications) or formulary exception (non-formulary medications) request
    ii. Requested therapy/dose/product has been approved by the FDA to treat the member condition or is recognized as safe and effective based on medical literature
    iii. Medical necessity has been demonstrated by:
        a. Member meets HCU criteria, if available
        b. No alternative therapy with same or similar mechanism of action is available on formulary
        c. No alternative therapy with same or similar efficacy is on formulary
        d. Member has been on this therapy/dose/product and documentation provided demonstrates all the of following:
            1. Condition has remained stable or improved
            2. Member has been adherent to therapy for at least the last 60 days
            3. Discontinuation of the agent WILL likely cause serious harm to member resulting in hospitalization, use of other health resources or death
    iv. A different non-formulary medication would not be more cost effective
    v. Allowing a formulary exception will likely result in significant cost savings to the plan
G. To avoid a lapse in current and on-going treatment, non-participating providers will be allowed for continuation of care for up to 90 days while transitioning the member to a participating provider.
H. Exceptions may be made on a case-by-case basis according to medical necessity.

2. Dosage

A. Dosing must be in accordance with US Food and Drug Administration (FDA) approved package insert.
    i. The professional provider must supply supporting documentation (i.e., published peer-reviewed literature) in order to request coverage for any dose outside of the Food and Drug (FDA) package insert listed in this

policy. For a list of HCU-recognized pharmacology compendia, view our policy on off-label coverage for prescription drugs and biologics.

3. **Exclusions/Contraindications**
    A. The prior use of samples will not be considered in the determination of a member's eligibility for coverage for this medication.

Lines of Business

1. **Health Choice Utah**
    A. Health Choice Utah Medicaid

References:

1. https://www.fda.gov/drugs/drug-information-consumers/orphan-products-hope-people-rare-diseases

Date	Review, Revisions, Approvals
01/01/2022	Health Choice Utah policy created. Review of package inserts and references
01/27/2022	Policy reviewed and approved by P&T Committee. Policy effective 02.01.2022
05/18/2023	Added and updated definitions Clarified abbreviations Clarified Policy Coverage 1D to when to apply a transition fill Clarified Policy Coverage 1E for when new members are eligible for a transition fill Clarified Policy Coverage 1F for when new members are eligible for longer than a transition fill Clarified Policy Coverage 1G for non-participating providers Added Policy Coverage 1H
05/18/2023	Policy reviewed and approved by P&T Committee via e-vote. Policy effective 05/22/2023
06/12/2024	Policy reviewed for annual update
07/29/2024	Policy reviewed and approved by P&T Committee via e-vote. Effective date 08.01.2024

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
CYSTADROPS® AND CYSTARAN® FOR OCULAR CYSTINOSIS

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:

Height/Weight:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Cystadrops® 0.37% (cysteamine ophthalmic gel solution), ☐ Cystaran® 0.44% (cysteamine ophthalmic solution)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.			
Questions	**Yes**	**No**	**Comments/Notes**
1. Is the prescribing provider a corneal specialist?	☐	☐	
2. Does documentation show a diagnosis of cystinosis including a leukocyte cysteine concentration of > 1.5 nmol half-cysteine per milligram of protein?	☐	☐	**Please provide documentation**
3. Does the member have cystine corneal crystals as shown by slit lamp examination?	☐	☐	**Please provide documentation**
4. Does documentation include a baseline Corneal Cystine Crystal Score (CCCS)?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☒	
2. Does documentation show a reduction of ≥ 1 unit in the Corneal Cystine Crystal Score (CCCS) after 6 months treatment?	☐	☐	**Please provide documentation**
3. Does documentation show an improvement in vision?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:
Physician Signature:

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-104
Origination Date: 01/01/2022
Reviewed/Revised Date: 01/29/2025
Next Review Date: 01/29/2026
Current Effective Date: 02/01/2025

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
SUNOSI

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Sunosi® (solfiamfetol)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
EXCESSIVE SOMNOLENCE ASSOCIATED WITH NARCOLEPSY			
1. Is the member 18 years of age or older?	☐	☐	
2. Does the member have a baseline ESS score of 15 or higher?	☐	☐	**Please provide documentation**
3. Does the member have a diagnosis of narcolepsy confirmed by polysomnography and MSLT?	☐	☐	**Please provide documentation**
4. Is Sunosi® prescribed by, or in consultation with, a sleep disorder specialist or neurologist?	☐	☐	
5. Has the member tried at least one agent from each of the following categories for at least 3 months each: • Central nervous system stimulant (e.g. methylphenidate) • Wakefulness promoting agent (e.g. modafinil)	☐	☐	**Please provide documentation**
6. Is the member's blood pressure adequately controlled?	☐	☐	**Please provide documentation**
7. Will the member be monitored for psychologic disorders or exacerbations?	☐	☐	
EXCESSIVE SOMNOLENCE ASSOCIATED WITH SLEEP APNEA			
1. Is the member 18 years of age or older?	☐	☐	
2. Does the member have a baseline ESS score of 15 or higher?	☐	☐	**Please provide documentation**
3. Does the member have a diagnosis of obstructive sleep apnea confirmed by a sleep disorder specialist with either polysomnography, or OCST?	☐	☐	**Please provide documentation**

4. Is Sunosi® prescribed by, or in consultation with, a sleep disorder specialist or pulmonologist?	☐	☐	
5. Is the member being treated with non-pharmacologic primary treatment modalities (CPAP or similar)?	☐	☐	**Please provide documentation**
6. Is the member at least 90% compliant on non-pharmacologic primary treatment modalities with at least 5 hours of use per night for at least 3 months prior to initiation of Sunosi®?	☐	☐	
7. Will the member continue to use CPAP therapy for at least 6 hours per night with at least 90% compliance during Sunosi® therapy?	☐	☐	
8. Has the member tried modafinil or armodafinil for at least 3 months while using CPAP?	☐	☐	**Please provide documentation**
9. Is the member's blood pressure adequately controlled?	☐	☐	**Please provide documentation**
10. Will the member be monitored for psychologic disorders or exacerbations?	☐	☐	
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does documentation show the member had an improvement in ESS score from baseline? • At least 5 point improvement for initial renewal • Maintenance of ESS score improvement for ongoing renewals	☐	☐	**Please provide documentation**
3. For OSA, has the member continued to use non-pharmacologic primary treatment modalities with at least 90% compliance for at least 6 hours per night?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-107
Origination Date: 01/01/2022
Reviewed/Revised Date: 07/29/2024
Next Review Date: 07/29/2025
Current Effective Date: 08/01/2024

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
Continuous Glucose Monitor (CGM)- Retail Pharmacy Only

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:

Height/Weight:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred: ☐ Dexcom G7, ☐ Dexcom G6, ☐ Freestyle Libre 1, ☐ Freestyle Libre 2, ☐ Freestyle Libre 3
Non-formulary: ☐ Dexcom G4, ☐ Dexcom G5, ☐ Eversense Implantable CGMs, ☐ Medtronic Enlite, ☐ Medtronic Guardian

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Does the member have type 1 diabetes mellitus?	☐	☐	**Please provide documentation**
2. Does the member have gestational diabetes or diabetes during pregnancy?	☐	☐	**Please provide documentation**
3. Does the member use an insulin pump?	☐	☐	**Please provide documentation**
4. Does the member have type 2 diabetes mellitus?	☐	☐	**Please provide documentation**
5. Does the member require multiple daily injections of insulin?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does documentation support active and routine use of device?	☐	☐	**Please provide documentation**
3. Does documentation show that the member is adhering to the treatment plan outlined by a diabetes specialist?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:
Physician Signature:

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy PHARM-HCU-108
Origination Date: 01/01/2022
Reviewed/Revised Date: 11/13/2024
Next Review Date: 11/13/2025
Current Effective Date: 12/01/2024

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
SIGNIFOR®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Signifor® (pasireotide)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Is the prescribing provider an endocrinologist?	☐	☐	
2. Does the member have a confirmed diagnosis of persistent or recurrent Cushing's disease evidenced by at least three 24-hour mean urinary free cortisol (mUFC) > 1.5 times the upper of normal (ULN)?	☐	☐	**Please provide documentation**
3. Has the member shown symptoms of Cushing's Disease, such as diabetes, central obesity, moon face, buffalo hump, osteoporosis, muscle wasting, hypertension, depression and/or anxiety?	☐	☐	**Please provide documentation**
4. Is the member a candidate for pituitary surgery?	☐	☐	**Please provide documentation**
5. If the member has had pituitary surgery, was it NOT curative?	☐	☐	**Please provide documentation**
6. Has the member tried and failed, or has a contraindication/intolerance, to at least two of the following: ketoconazole, Metopirone (metyrapone), Lysodren (mitotane), cabergoline?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the requesting for reauthorization of therapy?	☐	☐	
2. Does updated clinical documentation show stabilization of disease or absence of disease progression?	☐	☐	**Please provide documentation**
3. Does clinical documentation show a 24-hour urinary free cortisol below the upper limit of normal or a decrease by 50% from baseline?	☐	☐	**Please provide documentation**

4. Does the member have an absence of unacceptable drug toxicity?	☐	☐	

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:

Physician Signature:

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-109
Origination Date: 01/01/2022
Reviewed/Revised Date: 08/29/2024
Next Review Date: 08/29/2025
Current Effective Date: 09/01/2024

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
DESCOVY®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Descovy® (emtricitabine and tenofovir alafenamide)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
HIV INFECTION			
1. Does the member have documentation of renal dysfunction with creatinine clearance ≤ 50 mL/min for treatment dosing?	☐	☐	**Please provide documentation**
2. Does the member have documentation of tenofovir disoproxil fumarate induced renal dysfunction?	☐	☐	**Please provide documentation**
3. Did the member have new onset or worsening of renal dysfunction after starting a tenofovir disoproxil fumarate regimen?	☐	☐	**Please provide documentation**
4. Is the member taking any medications that are considered medically necessary and likely to cause or exacerbate renal dysfunction?	☐	☐	**Please provide documentation**
5. Does the member have an intolerance or contraindication to emtricitabine and tenofovir disoproxil fumarate (generic Truvada®)?	☐	☐	**Please provide documentation**
6. Does the member have documentation of osteoporosis confirmed by DEXA Scan OR do serial DEXA scans show osteopenia with progression of bone loss?	☐	☐	**Please provide documentation**
7. For treatment of HIV infection, will Descovy® be used as part of an antiretroviral treatment (ART) regimen?	☐	☐	**Please provide documentation**
PrEP			
1. Is the member at high risk for sexually acquired HIV-1 infection per the CDC guidelines?	☐	☐	**Please provide documentation**

2. Is the member confirmed to be HIV-negative within 30 days prior to initiation of therapy?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has Descovy shown to be tolerable and effective?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:

Physician Signature:

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-111
Origination Date: 01/01/2022
Reviewed/Revised Date: 01/29/2025
Next Review Date: 01/29/2026
Current Effective Date: 02/01/2025

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
DOJOLVI™

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Dojolvi™ (triheptanoin)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Is the therapy prescribed by, or in consultation with, a metabolic disease specialist or a physician who specializes in the management of long-chain fatty acid oxidation disorders?	☐	☐	
2. Does the member have a molecularly confirmed diagnosis of a long-chain fatty acid oxidation disorder based on 2 of the following: • Disease-specific acylcarnitine elevations on a newborn blood spot or in plasma • Enzyme activity assay (in cultured fibroblasts or lymphocytes) below the lower limit of normal • Genetic testing demonstrating pathogenic mutations in a gene associated long-chain fatty acid oxidation disorders	☐	☐	**Please provide documentation**
3. Has the member tried an over-the-counter medium-chain triglyceride product (e.g. nutraceutical supplements)?	☐	☐	**Please provide documentation**
4. Does the member have a history of a severe or recurrent manifestation of long-chain fatty acid oxidation disorders (i.e., cardiomyopathy, rhabdomyolysis, hypoglycemia)?	☐	☐	**Please provide documentation**
5. Will any other medium-chain triglyceride product(s) be used in combination with Dojolvi™?	☐	☐	
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	

2. Does updated clinical documentation show disease progression or toxicity to therapy?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.
Additional information:
Physician Signature:

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy PHARM-HCU-112
Origination Date: 01/01/2022
Reviewed/Revised Date: 01/29/2025
Next Review Date: 01/29/2026
Current Effective Date: 02/01/2025

Step Therapy

Policy: PHARM-HCU-115

Origination Date: 01/01/2022

Reviewed/Revised Date: 04/09/2025

Next Review Date: 04/09/2026

Current Effective Date: 05/01/2025

Disclaimer:

1. Policies are subject to change in accordance with Federal and State notice requirements.
2. Policies outline coverage determinations for Health Choice Utah (Medicaid). Refer to the "Policy" and "Lines of Business" section for more information.
3. Services requiring prior-authorization may not be covered, if the prior-authorization is not obtained.
4. This Pharmacy Policy does not guarantee coverage or payment of the service. The service must be a benefit in the member's plan and the member must be eligible for coverage at the time of service. Additional payment guidelines may be applied that are not included in this policy.

Purpose

To outline the step-therapy process to promote appropriate, safe, and effective utilization of drugs as guided by current clinical practice guidelines. This procedure describes how the step therapy process works for medications on the Health Plan pharmacy formulary. This will apply to all lines of business unless noted in the appendix.

Definitions

1. FDA: Food and Drug Administration
2. First Line Drug: medications that do not require use of another drug before coverage is considered
3. MM = Managed Medicaid
4. PBM: Pharmacy Benefit Manager
5. Second Line Drug: medications that require step therapy or use of a first line drug before coverage is considered unless medical necessity is determined
6. Step Therapy (ST): a process designed to assure that first line drugs, which have been proven to be safe and effective and that demonstrate greater value, are used before second line and potentially more costly alternatives are considered. Most brand medications with generic alternatives require ST with the generic product before the brand will be considered for authorization.

Policy/Coverage

1. **Policy**

A. Step therapy is a process designed to assure that first line drugs, which have been proven to be safe and effective and that demonstrate greater value, are used before second line and potentially more costly alternatives are considered. Most brand medications with generic alternatives require ST through the generic product before the brand will be considered for authorization.
    i. A point of sale edit on a second line drug claim which searches the claims adjudication system for first line drugs over a required period of time. If the first line drug(s) have been processed in the time period, the claims system may auto-approve a second line drug if all other requirements for coverage are met. If the step therapy requirement has not been met, the claim rejects for prior authorization.
B. When step therapy has not been met, a prior authorization is required.
C. Health Plans approves coverage through the prior authorization process for certain second line drugs as medically necessary when there is one of the following conditions:
    i. Documented failure of first line drugs
    ii. Inadequate response to first line drugs
    iii. Contraindication according to FDA label to first line drugs
    iv. Intolerance to first line drugs
D. If the conditions listed in C. above are not met, the request for coverage is denied.
E. Step Therapy Guidelines outline first and second line drugs along with parameters required for step therapy. These guidelines are determined and maintained by the Health Plan Pharmacy & Therapeutics Committee. The Step Therapy Guidelines are reviewed at least annually.

2. Procedure

A. Step Therapy Met, Claim Auto-Adjudicates
    i. If a member attempts to fill a drug that requires step therapy and has already met the step therapy requirement, the claim will auto-adjudicate at point-of-service.
B. Step Therapy Met, Claim Rejects
    i. If a member attempts to fill a drug that requires step therapy and has already met the step therapy requirement, the claim may reject for several reasons:
    ii. The member is new to the Plan
    iii. The member paid out of pocket (cash) for medications that fulfill step therapy requirements
    iv. No claims are in the claims system for medications that fulfill step therapy requirements
        a. For example, the member received samples or was getting it through a manufacture program.
C. When a member is attempting to fill a drug that requires step therapy and it rejects for any of the above reasons, the prescriber must submit a prior

authorization request providing documentation as to how the member has met the step therapy. The prior authorization request is reviewed by the PBM for determination of coverage.

D. The PBM notifies the practitioner of the prior authorization determination.
E. If the request is approved, an approval letter is sent to the member with a copy to the requesting provider.
F. If a request is denied, a denial letter is sent to the member with a copy to the requesting provider. The denial letter will include the following:
    i. Information regarding the specific reason for the denial, including reference to the information upon which the decision was based.
    ii. Appeal rights, along with an appeal rights form.
    iii. The prescriber is also notified of the option of discussing the decision further with a Pharmacist and the number where they may be reached.
G. The Prior Authorization process and notifications shall follow the time frame requirements.
H. Step Therapy Not Met, Claims Rejects
    i. If a member attempts to fill a drug that requires step therapy and has not met the step therapy requirement, the claim shall reject for prior authorization due to the step therapy not being met.
        a. The rejection message displayed to the pharmacy will state that step therapy is required and the medications needed to meet the step therapy.
    ii. Prescriber may submit a prior authorization request form for the prescribed medication stating why the member is unable to meet the step requirement with the appropriate clinical documentation and it shall be reviewed by the Clinical Pharmacy Team for determination of coverage.
    iii. If the request is approved, an approval letter is sent to the member with a copy to the requesting provider.
    iv. If a request is denied, a denial letter is sent to the member with a copy to the requesting provider. The denial letter will include the following:
        a. Information regarding the specific reason for the denial, including reference to the information upon which the decision was based.
        b. Appeal rights, along with an appeal rights form.
        c. The prescriber is also notified of the option of discussing the decision further with a Pharmacist and the number where they may be reached.
    v. The Prior Authorization process and notifications shall follow the time frame requirements.
    vi. Step therapy requirements are listed in Attachment A and will be updated as changes are made and new requirements are developed.

3. Appendix

A. Step Therapy Guidelines

i. Available upon request in response to relevant provider or member request.

Lines of Business

1. Health Choice Utah

A. Health Choice Utah Medicaid

Date	Review, Revisions, Approvals
01/01/2022	Health Choice Utah policy created.
03/24/2022	Policy reviewed and approved by the P&T Committee. Policy effective 04.01.2022
09/01/2022	Added step therapy guideline: REALRX_INSOMNIA Policy reviewed and approved by the P&T Committee. Policy effective 09.01.2022
10/27/2022	Update step therapy guidelines reviewed and approved by P&T Committee. REALRX_GLP-1 effective 11.01.22
02/28/2023	Updated step therapy guidelines: Updated: REALRX_SGLT-2 Added: REALRX_SGLT-2_CV and REALRX_SGLT-2_DPP-4
03/16/2023	Policy reviewed and approved by P&T Committee. Policy effective 04.01.2023
10/31/2023	Updated: REALRX_DPP-4 Added: REALRX_DPP-4 NP, REALRX_ROCKLATAN and RHOPRESSA
11/09/2023	Policy reviewed and approved by P&T Committee. Policy effective 12.01.2023
07/31/2024	Added step therapy guideline: REALRX_ZOLMITRIPTAN (NASAL ONLY)
08/29/2024	Policy reviewed and approved by P&T Committee via e-vote. Policy effective 09.01.2024
01/16/2025	Updated step therapy guideline: REALRX_DIFICID
01/29/2025	Policy reviewed and approved by P&T Committee. Policy effective 02.01.2025
04/01/2025	Added: REALRX_WINLEVI
04/09/2025	Policy reviewed and approved by P&T Committee. Policy effective 05.01.2025

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
EVRYSDI™

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Evrysdi™ (risdiplam)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Is the therapy prescribed by, or in consultation with, a neurologist with expertise in spinal muscular atrophy?	☐	☐	
2. Does the member have a confirmed diagnosis of spinal muscular atrophy (SMA) by molecular genetic testing of 5q SMA with one of the following: • 5q SMA homozygous gene deletion • 5q SMA homozygous gene mutation • Compound heterozygote mutation (e.g. deletion of SMN1 exon 7 and mutation of SMN1)?	☐	☐	Please provide documentation
3. Does documentation show the member has a diagnosis of SMA types 1, 2, or 3?	☐	☐	Please provide documentation
4. Is the member ≤ 25 years of age?	☐	☐	
5. Is the member dependent on any of the following: • Invasive ventilation or tracheostomy • Non-invasive ventilation support beyond naps and nighttime sleep?	☐	☐	Please provide documentation
6. Does the provider attest the member is not currently pregnant and has been counseled to use effective contraception during treatment and until 1 month after the last Evrysdi™ dose?	☐	☐	
7. Does the member have hepatic dysfunction?	☐	☐	
8. Has the member received Zolgensma®?	☐	☐	

9. Is the member currently taking Spinraza® or will Spinraza® be started in addition to Evrysdi™?	☐	☐	
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member responded to initial therapy as shown by maintenance, improvement, or decreased decline in motor function?	☐	☐	Please provide documentation
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-117
Origination Date: 01/01/2022
Reviewed/Revised Date: 04/09/2025
Next Review Date: 04/09/2026
Current Effective Date: 05/01/2025

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
LUPKYNIS™

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Lupkynis™ (voclosporin)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.			
Questions	**Yes**	**No**	**Comments/Notes**
1. Is the request made by, or in consultation with, a nephrologist or rheumatologist?	☐	☐	
2. Does documentation show the member has autoantibody-positive systemic lupus erythematosus (SLE), defined as anti-nuclear antibodies [ANA] greater than the laboratory reference range and/or anti-double-stranded DNA [anti-dsDNA] greater than 2 times the laboratory reference range?	☐	☐	**Please provide documentation**
3. Does documentation include a kidney biopsy showing a histological diagnosis of lupus nephritis Class III, IV, or V?	☐	☐	**Please provide documentation**
4. Is the member's recent eGFR ≥ 45 mL/min/1.73m^2?	☐	☐	**Please provide documentation**
5. Does the member have a history of kidney transplant?	☐	☐	
6. Has the member had a trial and failure, or contraindication/intolerance, to Benlysta (belimumab)?	☐	☐	**Please provide documentation**
7. Does documentation show Lupkynis™ will be used concurrently with mycophenolate or azathioprine AND a systemic steroid?	☐	☐	**Please provide documentation**
8. For women of childbearing potential, does the member have a negative serum pregnancy test at screening and negative urine pregnancy test at baseline?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	

2. Has the member been compliant with background immunosuppressive therapy?	☐	☐	
3. Has the member had a positive response to Lupkynis™, such as improvement or stability in renal function, reduction in flares, reduction in corticosteroid dose, decrease of anti-dsDNA titer and/or improvement in complement levels?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:

Physician Signature:

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request ****

Policy PHARM-HCU-118
Origination Date: 01/01/2022
Reviewed/Revised Date: 05/11/2023
Next Review Date: 05/11/2024
Current Effective Date: 06/01/2023

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
CABENUVA® & VOCABRIA®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested:) ☐ Cabenuva® (Cabotegravir/rilpivirine), ☐ Vocabria® (cabotegravir)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Is the request made by, or in consultation with, an infectious disease specialist?	☐	☐	
2. Does documentation show the member is HIV (human immunodeficiency) positive?	☐	☐	**Please provide documentation**
3. Does documentation show a current HIV viral load <50 copies/mL?	☐	☐	**Please provide documentation**
4. Has the member been stable on an antiretroviral regimen for at least the past 12 months?	☐	☐	**Please provide documentation**
5. Does documentation show a history of treatment failure?	☐	☐	**Please provide documentation**
6. Is there known or suspected virologic resistance to cabotegravir or rilpivirine?	☐	☐	**Please provide documentation**
7. Does documentation show that the member has the ability and willingness to visit the clinic to receive injection?	☐	☐	**Please provide documentation**
8. Does the member have an active hepatitis B virus (HBV) infection?	☐	☐	**Please provide documentation**
9. Has the member tried and failed all appropriate preferred HIV regimens?	☐	☐	**Please provide documentation**
10. Does documentation show the member has one of the following: • Severe gastrointestinal issues that likely limits absorption or tolerance of oral medications	☐	☐	**Please provide documentation**

• Social circumstances or mental capacity issues that make compliance with an oral antiretroviral regimen unlikely?			
11.Is the member pregnant or planning to become pregnant?	☐	☐	
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
LIVTENCITY®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Livtencity® (maribavir)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
CYTOMEGALOVIRUS (CMV) WITH POST-TRANSPLANT CMV INFECTION/DISEASE			
1. Is the member 12 years of age or older?	☐	☐	
2. Does the member weigh at least 35 kg?	☐	☐	**Please provide documentation**
3. Is the requesting provider an infectious disease specialist, hematologist, oncologist, or transplant specialist?	☐	☐	
4. Is the member a recipient of hematopoietic stem cell or solid organ transplant?	☐	☐	**Please provide documentation**
5. Has the member tried and failed, or have a contraindication, intolerance, or resistance to all of the following medications: • Ganciclovir or valganciclovir, foscarnet, and cidofovir	☐	☐	**Please provide documentation**
6. Is the member on any other CMV antivirals?	☐	☐	**Please provide documentation**
7. Is the member pregnant?	☐	☐	

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:
Physician Signature:

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy PHARM-HCU-127
Origination Date: 12/17/2021
Reviewed/Revised Date: 09/18/2024
Next Review Date: 09/18/2025
Current Effective Date: 10/01/2024

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
OXERVATE®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Oxervate® (cenergermin-bkbj)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
NEUROTROPHIC KERATITIS			
1. Is the member 18 years of age or older?	☐	☐	
2. Is the requesting provider an ophthalmologist?	☐	☐	
3. Does the member have a diagnosis of stage 2 or 3 neurotrophic keratitis in one or both eyes?	☐	☐	**Please provide documentation**
4. Has corneal sensation been measured and shows reduction?	☐	☐	**Please provide documentation**
5. Has the member experienced persistent epithelial defects (PED) of at least 2 weeks or more that is refractory to treatment with one or more conventional treatments for neurotrophic Keratitis (artificial tears, gel, or ointment)?	☐	☐	**Please provide documentation**
6. Does the member have a best corrected distance visual acuity (BCDVA) score of ≤ 75 Early Treatment Diabetic Retinopathy Study (ETDRS) letters, (≥ + 0.2 LogMAR, ≤ 20/32 Snellen or ≤ 0.625 decimal fraction) in the affected eye?	☐	☐	**Please provide documentation**
7. Has the member received Oxervate in the past?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:
Physician Signature:

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy PHARM-HCU-128
Origination Date: 11/15/2021
Reviewed/Revised Date: 08/29/2024
Next Review Date: 08/29/2025
Current Effective Date: 09/01/2024

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
LEQVIO®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Leqvio® (inclisiran)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
HETEROZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA			
1. Is the request made by, or in consultation with, a cardiologist, endocrinologist, lipidologist, or a physician who focuses in the treatment of cardiovascular risk management and/or lipid disorders?	☐	☐	**Please provide documentation**
2. Does the member have a diagnosis of heterozygous familial hypercholesterolemia (HeFH) confirmed by either of the following: • Untreated LDL-C level ≥ 190 mg/dL in adults • Untreated LDL-C level ≥ 160 mg/dL and tendon xanthoma in members < 20 years of age	☐	☐	**Please provide documentation**
3. Does the member have one of the following: • Genetic confirmation testing that demonstrates LDL-R mutation, LDLRAP1 mutation, familial defective apo B100, or a PCSK9 mutation • A diagnosis confirmed by the World Health Organization/Dutch Lipid Network Criteria resulting in a score > 8 points • A diagnosis meeting the threshold for definite or possible/probable familial hypercholesterolemia per Simon Broome Criteria • Arcus senilis if < 45 years of age	☐	☐	**Please provide documentation**

• Have a first degree relative with similarly elevated LDL-C, early ASCVD (<55 years of age for men, <65 years of age for women), tendon xanthoma, or corneal arcus			
4. Does clinical documentation show a recent baseline low-density lipoprotein cholesterol (LDL-C) level?	☐	☐	**Please provide documentation**
5. Has the member failed to reach target LDL-C when on high-intensity statin therapy or maximally tolerated statin therapy for at least 8 continuous weeks and LDL-C remains ≥ 100 mg/dL?	☐	☐	**Please provide documentation**
6. Does the member show LDL-C is unresponsive to standard PCSK9 therapy for an adequate duration (i.e., 3-6 months)? • Documentation must show trial and failure to Repatha®	☐	☐	**Please provide documentation**
7. Will Leqvio® be used concurrently with a maximally tolerated statin therapy?	☐	☐	**Please provide documentation**
8. If the member has a contraindication to all statins, does documentation show one of the following: • Active liver disease • Diagnosis or history of rhabdomyolysis • Pregnant or nursing mothers • Allergic reaction with rash and/or anaphylactic symptoms	☐	☐	**Please provide documentation**
9. If the member has a hypersensitivity to statins, does documentation show all of the following: • Inability to tolerate at least 2 different statins at the lowest starting dose • Intolerance associated with confirmed, intolerable statin-related adverse effects or significant biomarker abnormalities • Symptom and/or biomarker resolution upon discontinuation • Attestation that adverse effects are not attributable to drug-drug interactions or recognized conditions that can cause similar changes (e.g., hypothyroidism) • Intolerance persists despite trials of all the following: low dose of same or different statin, statin is dosed intermittently, and alternate cholesterol lowering medications such as ezetimibe or a bile-acid sequestrant such as colesevelam is used	☐	☐	**Please provide documentation**
10. Is the member at least 80% compliant for at least 6 months with their baseline therapy (i.e., statins, ezetimibe)?	☐	☐	**Please provide documentation**
11. Has the addressed lifestyle modifications (i.e., a heart healthy diet, the importance of exercise, and smoking cessation) been completed?	☐	☐	**Please provide documentation**
12. Will the member be concurrently receiving any of the following medications in combination with Leqvio®: • Praluent® (alirocumab) • Repatha® (evolocumab) • Nexletol® (bempedoic acid) • Nexlizet® (bempedoic acid and ezetimibe)	☐	☐	**Please provide documentation**
HIGH RISK OF ATHEROSCLEROTIC CARDIOVASCULAR DISEASE (ASCVD)			
1. Is the request made by, or in consultation with, a cardiologist, endocrinologist, lipidologist, or a physician who focuses in the treatment of cardiovascular risk management and/or lipid disorders?	☐	☐	**Please provide documentation**

2. Does the member have a diagnosis of high risk atherosclerotic cardiovascular disease (ASCVD) with one of the following: • History of myocardial infarction • Non-hemorrhagic stroke • Symptomatic peripheral artery disease • Acute coronary syndromes • Coronary artery disease • Stable or unstable angina • Coronary or other arterial revascularization • Transient ischemic attack • Diabetes • 10-year Framingham risk score of 20% or higher	☐	☐	**Please provide documentation**
3. Does clinical documentation show a recent baseline low-density lipoprotein cholesterol (LDL-C) level?	☐	☐	**Please provide documentation**
4. Has the member failed to reach target LDL-C when on high-intensity statin therapy or maximally tolerated statin therapy for at least 8 continuous weeks and LDL-C remains ≥ 70 mg/dL?	☐	☐	**Please provide documentation**
5. Does the member show LDL-C is unresponsive to standard PCSK9 therapy for an adequate duration (i.e., 3-6 months)? • Documentation must show trial and failure to Repatha®	☐	☐	**Please provide documentation**
6. Will Leqvio® be used concurrently with a maximally tolerated statin therapy?	☐	☐	**Please provide documentation**
7. If the member has a contraindication to all statins, does documentation show one of the following: • Active liver disease • Diagnosis or history of rhabdomyolysis • Pregnant or nursing mothers • Allergic reaction with rash and/or anaphylactic symptoms	☐	☐	**Please provide documentation**
8. If the member has a hypersensitivity to statins, does documentation show all of the following: • Inability to tolerate at least 2 different statins at the lowest starting dose • Intolerance associated with confirmed, intolerable statin-related adverse effects or significant biomarker abnormalities • Symptom and/or biomarker resolution upon discontinuation • Attestation that adverse effects are not attributable to drug-drug interactions or recognized conditions that can cause similar changes (e.g., hypothyroidism) • Intolerance persists despite trials of all the following: low dose of same or different statin, statin is dosed intermittently, and alternate cholesterol lowering medications such as ezetimibe or a bile-acid sequestrant such as colesevelam is used	☐	☐	**Please provide documentation**
9. Is the member at least 80% compliant for at least 6 months with their baseline therapy (i.e., statins, ezetimibe)?	☐	☐	**Please provide documentation**
10. Has the provider addressed lifestyle modifications (i.e., a heart healthy diet, the importance of exercise, and smoking cessation) been completed?	☐	☐	**Please provide documentation**

11. Will the member be concurrently receiving any of the following medications in combination with Leqvio®: • Praluent® (alirocumab) • Repatha® (evolocumab) • Nexletol® (bempedoic acid), • Nexlizet® (bempedoic acid and ezetimibe)	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does documentation indicate an adequate reduction in LDL-C defined by one of the following: • ≥ 40% reduction in LDL-C level compared to baseline or reduction to LDL goal in members with a diagnosis of ASCVD • Reduction in LDL-C level compared to baseline in members with a diagnosis of HeFH	☐	☐	**Please provide documentation**
3. Is member adherent to concurrent statin therapy at the maximum tolerated dose?	☐	☐	**Please provide documentation**
4. Is member adherent to lifestyle modifications (i.e., a heart healthy diet, the importance of exercise, and smoking cessation)?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-130
Origination Date: 02/09/2022
Reviewed/Revised Date: 09/18/2024
Next Review Date: 09/18/2025
Current Effective Date: 10/01/2024

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
REZUROCK™

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Rezurock™ (belumosudil)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
CHRONIC GRAFT-VERSUS-HOST DISEASE			
1. Does the member have a diagnosis of chronic graft-versus-host disease?	☐	☐	**Please provide documentation**
2. Does documentation show trial and failure of at least two systemic treatments (i.e., methylprednisolone, Imbruvica (ibrutinib), cyclosporine, tacrolimus, sirolimus, mycophenolate mofetil, imatinib)?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the requesting for reauthorization of therapy?	☐	☐	
2. Does clinical documentation show continued medical necessity and evidence of a positive clinical response to therapy?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:
Physician Signature:

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-131
Origination Date:12/17/2021
Reviewed/Revised Date: 05/27/2025
Next Review Date: 05/27/2026
Current Effective Date: 06/01/2025

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
APRETUDE®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Apretude ® (cabotegravir)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Is the request for an at-risk adult or adolescent (≥ 35 kg) to reduce the risk of sexually acquired HIV-1 infection?	☐	☐	**Please provide documentation**
2. Is the member confirmed to be HIV-negative within 30 days prior to initiation of therapy?	☐	☐	**Please provide documentation**
3. Does the member have an intolerance or contraindication to emtricitabine and tenofovir disoproxil fumarate (generic Truvada®)?	☐	☐	**Please provide documentation**
4. Does the member have documentation of tenofovir disoproxil fumarate induced renal dysfunction?	☐	☐	**Please provide documentation**
5. Did the member have new onset or worsening of renal dysfunction after starting a tenofovir disoproxil fumarate regimen?	☐	☐	**Please provide documentation**
6. Is the member taking any medications that are considered medically necessary and likely to cause or exacerbate renal dysfunction?	☐	☐	**Please provide documentation**
7. Does the member have documentation of renal dysfunction with creatinine clearance <60 mL/min?	☐	☐	**Please provide documentation**
8. Does the member have documentation of osteoporosis confirmed by DEXA Scan OR do serial DEXA scans show osteopenia with progression of bone loss?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	

2. Has Apretude shown to be tolerable and effective?	☐	☐	**Please provide documentation**
3. Does the member have a continued medical need for therapy?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:

Physician Signature:

****Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy PHARM-HCU-134
Origination Date: 05/09/2022
Reviewed/Revised Date: 12/30/2024
Next Review Date: 12/30/2025
Current Effective Date: 01/01/2025

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM

Brand Name Atopic Dermatitis Agents

Adbry™, Cibinqo™, Dupixent®, Eucrisa®, Opzelura™, Rinvoq®, Zoryve™

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:

Height/Weight:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Adbry™, ☐ Cibinquo™, ☐ Dupixent® (dupilumab), ☐ Eucrisa®, ☐Opzelura™, ☐Rinvoq®, ☐Zoryve™ 0.15% cream

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
MILD TO MODERATE ATOPIC DERMATITIS			
1. Is the request made by, or in consultation with, a provider specializing in dermatology, allergy, or immunology?	☐	☐	
2. Does the member have a diagnosis of mild to moderate atopic dermatitis?	☐	☐	**Please provide documentation**
3. Is the affected area less than 20% of body surface area?	☐	☐	**Please provide documentation**
4. Does the quantity requested exceed one tube per 30 days?	☐	☐	
5. Has the member had an adequate trial with the following, where appropriate: • a topical calcineurin inhibitor, such as pimecrolimus or tacrolimus, • two medium to high potency corticosteroids (e.g., triamcinolone acetonide 0.1%, mometasone furoate 0.1%, betamethasone dipropionate 0.05%, desoximetasone 0.05%), and • phototherapy?	☐	☐	**Please provide documentation**
MODERATE TO SEVERE ATOPIC DERMATITIS			
1. Is the request made by a provider specializing in dermatology, allergy, or immunology?	☐	☐	

2. Does the member have a diagnosis of moderate to severe atopic dermatitis with an affected body surface area more than 10%?	☐	☐	**Please provide documentation**
3. Has the member tried at least two moderate to very high potency prescription corticosteroids?	☐	☐	**Please provide documentation**
4. If unable to tolerate corticosteroids due to the treatment area (e.g. face, genitals, etc.), has the member tried a calcineurin inhibitor, such as topical tacrolimus?	☐	☐	**Please provide documentation**
5. Has the member tried phototherapy?	☐	☐	**Please provide documentation**
6. Has the member tried at least one of the following in the past 6 months: • oral corticosteroid • intramuscular steroid • cyclosporine • azathioprine • methotrexate • mycophenolate	☐	☐	**Please provide documentation**
7. If the request is for Cibinqo, • has the member had an inadequate response to a 3-month trial of Dupixent and Adbry, and • has Tb and Hepatitis screenings been performed?	☐	☐	**Please provide documentation**
8. If the request is for Rinvoq, • has the member had an inadequate response to a 3-month trial of Dupixent, Adbry and Cibinqo, and • has Tb and Hepatitis screenings been performed?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of atopic dermatitis therapy?	☐	☐	
2. Is there evidence of a positive clinical response?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:

Physician Signature:

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy PHARM-HCU-135
Origination Date: 04/20/2022
Reviewed/Revised Date: 01/29/2025
Next Review Date: 01/29/2026
Current Effective Date: 02/01/2025

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM

Non-Radiographic Axial Spondyloarthritis (nrx-SpA)

Avsola®, Cimzia®, Cosentyx®, Inflectra®, infliximab, Remicade®, Renflexis®, Taltz®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-formulary drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred/Non-Formulary:

1. **1st Line Preferred agents:**
   A. Infliximab products: Avsola® (infliximab-axxq), Inflectra® (infliximab-dyyb), infliximab, Remicade (infliximab), Renflexis® (infliximab-abda)
2. **2nd line preferred agents with single step; after trial and failure of 1 preferred first line agent:**
   A. Cimzia® (certolizumab), Taltz® (ixekizumab)
3. **Non-Formulary agents with a triple step; after trial and failure of 1 preferred first line agent and 2 second line agents:**
   A. Cosentyx® (secukinumab)

Product being requested: _____

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Is the member 18 years of age or older with Non-Radiographic Axial Spondyloarthritis?	☐	☐	**Please provide documentation**
2. Is the requesting provider a rheumatologist or in consultation with one?	☐	☐	
3. Does documentation show an adequate trial and failure of at least one prescription strength nonsteroidal anti-inflammatory drug (NSAID) at the maximally tolerated dose, unless contraindicated?	☐	☐	**Please provide documentation**
4. Has the provider performed tuberculosis (TB) screening prior to therapy initiation?	☐	☐	**Please provide documentation**
5. For tumor necrosis factor inhibitors (TNFIs), has the provider preformed Hepatitis B screening prior to therapy initiation?	☐	☐	**Please provide documentation**

REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does updated documentation show that the member has a continued medical need?	☐	☐	**Please provide documentation**
3. Has the provider performed continued tuberculosis screening during therapy?	☐	☐	**Please provide documentation**
4. Has the provider performed continued Hepatitis B monitoring in HBV carriers?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-142
Origination Date: 07/28/2022
Reviewed/Revised Date: 09/01/2022
Next Review Date: 09/01/2023
Current Effective Date: 09/01/2022

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
NUCALA®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department.

- For **Medical Pharmacy** please fax requests to: 801-646-7300
- For **Retail Pharmacy** please fax requests to: 385-425-4052

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being request: ☐ Nucala® (mepolizumab)

Dosing/Frequency:_____

Note: for the treatment of nasal polyps see Chronic Rhinosinusitis with Nasal Polyposis (CRSwNP); for the treatment of Eosinophilic Granulomatosis with Polyangiitis (EGPA) see Eosinophilic Granulomatosis with Polyangiitis (EGPA)

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
HYPEREOSINOPHILIC SYNDROME			
1. Has the member had a diagnosis of hypereosinophilic syndrome for at least 6 months without an identifiable non-hematologic secondary cause?	☐	☐	**Please provide documentation**
2. Does documentation show the member is negative for platelet-derived growth factor receptor alpha (*PDGFRA*) and FIP1L1?	☐	☐	**Please provide documentation**
3. Has the member been on a stable dose of oral corticosteroids, immunosuppressants, or cytotoxic therapy such as hydroxyurea or methotrexate for at least 4 months prior to Nucala® therapy initiation?	☐	☐	**Please provide documentation**
4. Does the member have a blood eosinophil count > 1,500 eosinophils/µL on 2 examinations at least 1 month apart and/or presence of tissue eosinophilia?	☐	☐	**Please provide documentation**
5. Have other causes of elevated eosinophils and/or organ damage been ruled out?	☐	☐	**Please provide documentation**
NUCALA FOR ASTHMA			
1. Does the member have a confirmed diagnosis of eosinophilic asthma?	☐	☐	

2. Has the member tried and failed or have a contraindication or intolerance to the preferred product Fasenra® (benralizumab)?	☐	☐	
3. Does documentation show the member's baseline eosinophil count?	☐	☐	**Please provide documentation**
4. Is the request made by an asthma specialist, allergist, immunologist, or pulmonologist?	☐	☐	
5. Has the member been at least 80% compliant with a high-dose inhaled corticosteroid (ICS)/long-acting inhaled beta-2-agonist (LABA) inhaler for at least the past 6 months?	☐	☐	**Please provide documentation**
6. Does the member have poor asthma control, defined as two or more acute exacerbations in the past 12 months requiring additional medical treatment?	☐	☐	**Please provide documentation**
7. Does documentation show the member's forced expiratory volume (FEV1) is < 80%?	☐	☐	**Please provide documentation**
8. Are underlying conditions or triggers for asthma or pulmonary disease maximally managed?	☐	☐	
9. Is the member an active smoker? If yes, does documentation show that smoking cessation has been addressed?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
For Hypereosinophilic Syndrome			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does documentation show a positive response to therapy evidenced by a reduction in frequency of HES flares?	☐	☐	**Please provide documentation**
For Asthma			
Is the request for reauthorization?	☐	☐	
Does updated documentation show sustained clinical improvement from baseline, such as decreased nighttime awakenings, improved FEV1, reduced missed days from work/school, decreased daytime symptoms, etc.?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:

Physician's Signature:

****Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-144
Origination Date: 09/27/2022
Reviewed/Revised Date: 05/27/2025
Next Review Date: 05/27/2026
Current Effective Date: 06/01/2025

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
HYFTOR®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Hyftor® (topical sirolimus)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Does the member have a definitive diagnosis of tuberous sclerosis complex by meeting one of the following: • Does documentation show identification of a pathogenic variant in the tuberous sclerosis complex 1 (TSC1) gene or tuberous sclerosis complex 2 (TSC2) gene by genetic testing, OR • Clinical documentation shows definitive diagnosis of tuberous sclerosis complex	☐	☐	**Please provide documentation**
2. Is the requesting provider a dermatologist or a prescriber who specializes in the management of individuals with tuberous sclerosis complex or in consultation with one?	☐	☐	**Please provide documentation**
3. Does the member have three or more facial angiofibromas that are at least 2 mm in diameter with redness in each?	☐	☐	**Please provide documentation**
4. Is the member candidate for laser therapy or surgery?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does updated documentation show that the member has a continued medical need?	☐	☐	**Please provide documentation**
3. Does updated documentation show the member responded to therapy, such as a decrease in the size and/or redness of the facial angiofibromas, as determined by the prescriber	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.
Additional information:
Physician Signature:

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU- 145
Origination Date: 10/06/2022
Reviewed/Revised Date: 01/29/2025
Next Review Date: 01/29/2026
Current Effective Date: 02/01/2025

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM

Chronic Rhinosinusitis with Nasal Polyposis (CRSwNP)

Dupixent®, Nucala®, Xolair®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred: ☐ Dupixent®(dupilumab), Nucala®(mepolizumab)
Non-preferred: ☐ Xolair®(omalizumab)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
DUPIXENT, NUCALA			
1. Does the member have a diagnosis of chronic rhinosinusitis with nasal polyposis confirmed by anterior rhinoscopy, nasal endoscopy, or computed tomography (CT)?	☐	☐	**Please provide documentation**
2. Is the request made by, or in consultation with, an allergist, pulmonologist or ENT specialist?	☐	☐	
3. Has the member had at least a three-month trial and failure of Xhance® (fluticasone) nasal spray, which requires prior authorization, in addition to saline lavage?	☐	☐	**Please provide documentation**
4. Has the member tried and failed at least two weeks of systemic corticosteroid therapy?	☐	☐	**Please provide documentation**
5. Has the member tried and failed at least two weeks of doxycycline or macrolide antibiotics?	☐	☐	**Please provide documentation**
6. Will the requested therapy be used in combination with an intranasal corticosteroid?	☐	☐	
XOLAIR			
1. Does the documentation include the current body weight and baseline serum IgE?	☐	☐	**Please provide documentation**

REAUTHORIZATION			
1. Is the request for reauthorization of chronic rhinosinusitis therapy?	☐	☐	
2. Has the member experienced a reduction in their nasal congestion and nasal polyp size?	☐	☐	
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy PHARM-HCU-146
Origination Date: 10/27/2022
Reviewed/Revised Date: 08/29/2024
Next Review Date: 08/29/2025
Current Effective Date: 09/01/2024

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM

Zoryve™

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Zoryve™ 0.3% cream, ☐ Zoryve™ 0.3% foam

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
SEBORRHEIC DERMATITIS			
1. Is the request made by, or in consultation with, a dermatologist, allergist or immunologist?	☐	☐	
2. Does the member have moderate to severe seborrheic dermatitis with an Investigator Global Assessment (IGA) of 3 or 4?	☐	☐	**Please provide documentation**
3. Does the member take any of the following medications? • Biologic DMARDs [e.g., Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab), Cosentyx (secukinumab), Stelara (ustedkinumab), Orencia (abatacept)]; OR • Janus Kinase Inhibitors [e.g., Xeljanz (tofacitinib), Oluminat (baricitinib), Rinvoq (upacitinib)]; OR • Phosphodiesterase 4 (PDE4) inhibitors [e.g., Otezla (apremilast)]	☐	☐	
4. Does documentation show failure or contraindication to ALL of the following? • topical antifungal • a medium to high potency corticosteroids (e.g., triamcinolone acetonide 0.1%, mometasone furoate 0.1%,	☐	☐	**Please provide documentation**

betamethasone dipropionate 0.05%, desoximetasone 0.05%); AND • a topical calcineurin inhibitor such as pimecrolimus or tacrolimus; AND • phototherapy; AND • oral antifungal			
PSORIASIS			
1. Is the request made by, or in consultation with, a dermatologist?	☐	☐	
2. Does the member have a diagnosis of psoriasis?	☐	☐	**Please provide documentation**
3. Does the member take any of the following medications? • Biologic DMARDs [e.g., Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab), Cosentyx (secukinumab), Stelara (ustedkinumab), Orencia (abatacept)]; OR • Janus Kinase Inhibitors [e.g., Xeljanz (tofacitinib), Oluminat (baricitinib), Rinvoq (upacitinib)]; OR • Phosphodiesterase 4 (PDE4) inhibitors [e.g., Otezla (apremilast)]	☐	☐	**Please provide documentation**
4. Is the affected area less than 20% of body surface area?	☐	☐	**Please provide documentation**
5. For eyelids, face, neck and genital areas, does documentation show failure or contraindication to topical calcineurin inhibitor, such as pimecrolimus or tacrolimus?	☐	☐	**Please provide documentation**
6. Does documentation show failure or contraindication to ALL of the following? • two medium to high potency corticosteroids (e.g., triamcinolone acetonide 0.1%, mometasone furoate 0.1%, betamethasone dipropionate 0.05%, desoximetasone 0.05%); AND • a topical calcineurin inhibitor such as pimecrolimus or tacrolimus; AND • phototherapy	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does the member show a continued medical need for the therapy?	☐	☐	**Please provide documentation**
3. Has the therapy been tolerable and effective?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			

Additional information:
Physician Signature:

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-147
Origination Date: 01/09/2023
Reviewed/Revised Date: 11/13/2024
Next Review Date: 11/13/2025
Current Effective Date: 12/01/2024

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM

MOUNJARO and GLP-1s

liraglutide, Mounjaro®, Ozempic®, Rybelsus®, Trulicity®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:

Height/Weight:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ liraglutide, ☐ Mounjaro®(tirzapatide), ☐ Ozempic® (semaglutide), ☐ Rybelsus®(semaglutide), ☐ Trulicity®(dulaglutide)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Does the requested member have a diagnosis of type 2 diabetes?	☐	☐	**Please provide documentation**
2. Has the member tried and failed generic metformin or a generic metformin-containing combination for at least 3 months?	☐	☐	
MOUNJARO®			
1. Has the member tried and failed a preferred GLP-1 without desired effect?	☐	☐	
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does the member show a continued medical need for the therapy?	☐	☐	**Please provide documentation**
3. Has the therapy been tolerable and effective?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:
Physician Signature:

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-148
Origination Date: 01/11/2023
Reviewed/Revised Date: 06/11/2025
Next Review Date: 06/11/2026
Current Effective Date: 07/01/2025

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
HEAVILY TREATED HIV
Rukobia™, Sunlenca®, Trogarzo®

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested:

1. Preferred:
    a. Sunlenca® (lenacapavir)
2. Non-Formulary:
    a. Rukobia™ (fostemsavir): Clinical documentation must show trial and failure of Sunlenca or medical necessity for oral administration
3. Non-Preferred:
    a. Trogarzo® (ibalizumab-uiyk): Clinical documentation must show trial and failure of Sunlenca and Rukobia

Product being requested: _____

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.			
Questions	**Yes**	**No**	**Comments/Notes**
1. Is the member diagnosed with multidrug resistant HIV-1 infection?	☐	☐	**Please provide documentation**
2. Is the requesting provider an HIV or infectious disease specialist, or in consultation with one?	☐	☐	
3. Is the member is currently failing an antiretroviral drug regimen in the treatment of HIV-1?	☐	☐	**Please provide documentation**
4. Is the member is adherent to antiretroviral regimen(s)?	☐	☐	**Please provide documentation**
5. Has the member has tried and failed at least three (3) of the following antiretroviral classes (failure is demonstrated by current or projected HIV resistance to all agent(s) within each class, or clinically significant adverse effects/contraindications to all agent(s) within each class)?	☐	☐	**Please provide documentation**

• Nucleoside reverse transcriptase inhibitors (NRTI) (e.g, abacavir, didanosine, emtricitabine, lamivudine, stavudine, tenofovir disoproxil fumarate, tenofovir alafenamide, zidovudine) • Non-nucleoside reverse transcriptase inhibitors (NNRTI) (e.g., delaviridine, efavirenz, etravirine, nevirapine, nevirapine XR, rilpivirine) • Protease inhibitors (PI) (e.g., atazanavir, darunavir, fosamprenavir, indinavir, nelfinavir, ritonavir, saquinavir, tipranavir) • Integrase inhibitors (e.g., raltegravir, dolutegravir, elvitegravir) • CCR5-antagonists (e.g., Selzentry® (maraviroc))			
6. Will the requested drug be used in combination with optimized background antiretroviral regimen(s)?	☐	☐	**Please provide documentation**
7. Does the member have a plasma HIV RNA viral load ≥ 400 copies/mL?	☐	☐	**Please provide documentation**
8. Does the member have a documented CD4 count within the past 30 days?	☐	☐	**Please provide documentation**
9. For Rukobia™, does clinical documentation show trial and failure of Sunlenca® or medical necessity for oral administration?	☐	☐	**Please provide documentation**
10. For Trogarzo®, does clinical documentation show trial and failure of Sunlenca® and Rukobia™?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does the member show a positive clinical response to therapy evidenced by a reduction of HIV RNA viral load and an increased CD4 count?	☐	☐	**Please provide documentation**
3. Is the member adherent to the HIV regimen and optimized background antiretroviral regimen(s)?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

** Failure to submit clinical documentation to support this request will result in a dismissal of the request.**

Policy: PHARM-HCU-149
Origination Date: 03/09/2023
Reviewed/Revised Date: 12/30/2024
Next Review Date: 12/30/2025
Current Effective Date: 01/01/2025

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM

HORMONE THERAPY FOR GENDER DYSPHORIA

Testosterone products, estradiol products

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ testosterone products ☐ estradiol products ☐ anti-androgens ☐ leuprolide

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
GENDER DYSPHORIA IN CHILDREN/ADOLESCENTS			
1. Is the member <18 years of age?	☐	☐	
2. Was the member diagnosed with gender dysphoria prior to January 28, 2023?	☐	☐	**Please provide documentation**
3. Does documentation demonstrate that the provider has been treating the patient for gender dysphoria for at least 6 months?	☐	☐	**Please provide documentation**
4. Has a health evaluation been completed by a medical health professional that includes the following: • the medical health professional is different from the provider providing the hormonal transgender treatment • has a transgender treatment certification • documentation of the diagnosis of gender dysphoria	☐	☐	**Please provide documentation**
5. Is the requesting provider an endocrinologist or physician who is experienced in hormonal therapy treatments in pediatric and adolescent patients, or in consultation with one?	☐	☐	
6. Does documentation include written consent from the member and the member's parent/guardian, unless the member is emancipated?	☐	☐	**Please provide documentation**
7. If the request is for leuprolide, does documentation show Tanner stage ≥2?	☐	☐	**Please provide documentation**

8. If the request is for leuprolide, is the request for Eligard?	☐	☐	**If no, clinical documentation must include a medical reason why the member cannot use the preferred agent Eligard**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-150
Origination Date: 03/09/2023
Reviewed/Revised Date: 07/29/2024
Next Review Date: 07/29/2025
Current Effective Date: 08/01/2024

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
RADICAVA®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Radicava (edaravone) oral suspension

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Is the prescriber a neurologist, neuromuscular disease specialist, or a physician specialized in amyotrophic lateral sclerosis (ALS)?	☐	☐	
2. Does the member have a Forced Vital Capacity of 80% or greater?	☐	☐	**Please provide documentation**
3. Has the member had a duration of the disease for 2 years or less?	☐	☐	**Please provide documentation**
4. Is the member currently taking riluzole OR have clinical documentation showing a contraindication to riluzole therapy?	☐	☐	**Please provide documentation**
5. Does the member have documentation showing an ALSFRS-R score?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:
Physician Signature:

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-152
Origination Date: 01/05/2023
Reviewed/Revised Date: 11/13/2024
Next Review Date: 11/13/2025
Current Effective Date: 12/01/2024

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
POSACONAZOLE

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ posaconazole tablets, ☐ posaconazole solution

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
Prophylaxis of Invasive Aspergillus or Candida Infection			
1. Is the request for prophylaxis of Invasive Aspergillus Infection or Candida infection?	☐	☐	
2. Is the member severely immunocompromised as defined by at least one of the following? • Member is status post hematopoietic stem cell transplant with current, significant graft-versus-host disease receiving immunosuppressive therapies • Member has a hematologic malignancy with neutropenia	☐	☐	**Please provide documentation**
Fungal Infection Treatment			
1. Is request made by, or in consultation with, an Infectious Disease Specialist?	☐	☐	**Please provide documentation**
2. Does the member have a diagnosis of one of the following? • Refractory coccidioidomycosis, • Invasive mucormycosis, • Oropharyngeal candidiasis, • Invasive *Aspergillus* infection (Aspergillosis)	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.
Additional information:
Physician Signature:

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-153
Origination Date: 05/04/2023
Reviewed/Revised Date: 09/18/2024
Next Review Date: 09/18/2025
Current Effective Date: 10/01/2024

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
OPZELURA™ FOR TREATMENT OF NONSEGMENTAL VITILIGO

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Opzelura™ (ruxolitinib)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Is the request by, or in consultation with, a dermatologist?	☐	☐	**Please provide documentation**
2. Have other causes of depigmentation been ruled out (e.g., nevus depigmentosus, pityriasis alba, idiopathic guttate hypomelanosis, tinea (pityriasis) versicolor, halo nevus, piebaldism, progressive macular hypomelanosis, lichen sclerosus, chemical leukoderma, drug-induced leukoderma, hypopigmented mycosis fungoides)?	☐	☐	**Please provide documentation**
3. Does the affected area exceed 10% body surface area?	☐	☐	**Please provide documentation**
4. Does the member have history of failure, contraindication, or intolerance to ALL of the following? • Two medium to high potency corticosteroids (e.g., triamcinolone acetonide 0.1%, mometasone furoate 0.1%, betamethasone dipropionate 0.05%, desoximetasone 0.05%) • Topical calcineurin inhibitor, such as pimecrolimus or tacrolimus • Phototherapy	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does clinical documentation show achievement and maintenance of positive clinical response?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.
Additional information:
Physician Signature:

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-156
Origination Date: 10/11/2023
Reviewed/Revised Date: 09/18/2024
Next Review Date: 09/18/2025
Current Effective Date: 10/01/2024

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
TEZSPIRE™

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Tezspire™ (tezepelumab-ekko)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
SEVERE ASTHMA			
1. Does the member have a diagnosis of severe asthma and documentation of at least one of the following: • Symptoms throughout the day • Nighttime awakenings, often 7 times per week • SABA use for symptom control occurs several times per day • Extremely limited normal activities • Lung function (percent predicted FEV1) <60%	☐	☐	**Please provide documentation**
2. Is the request made by an asthma specialist (allergist, immunologist, or pulmonologist)?	☐	☐	**Please provide documentation**
3. Has the member been ≥80% compliant with a high-dose inhaled corticosteroid (ICS)/long-acting inhaled beta-2-agonist (LABA) inhaler for at least the past 5 months?	☐	☐	**Please provide documentation**
4. Does clinical documentation show poor asthma control, defined by the following: • ≥2 acute exacerbations in a 12-month period requiring additional medical treatment, including emergency department (ED) visits, hospitalizations, or frequent office visits, etc.	☐	☐	**Please provide documentation**
5. Does the member have a baseline forced expiratory volume in 1 second (FEV_1) < 80%? • Note: For members age 12 to 17, FEV_1 must be < 90%	☐	☐	**Please provide documentation**

6. Does the member have a medical reason that they cannot use Dupixent® (dupilumab), anti-IL5 agents (i.e., Fasenra® (benralizumab)) and Xolair® (omalizumab) such as: • Trial and failure or contraindication/intolerance to all agents • Member does not meet Dupixent® and anti-IL5 agents criteria based on eosinophil count and member does not meet Xolair® criteria based on IgE levels and/or aeroallergen skin test	☐	☐	**Please provide documentation**
7. Will Tezspire™ be used in combination with anti-IL4, anti-IL5, or anti-IgE monoclonal antibody agents?	☐	☐	**Please provide documentation**
8. Is smoking cessation addressed, if applicable?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the requesting for reauthorization of therapy?	☐	☐	**Please provide documentation**
2. Does clinical documentation show a positive clinical response to therapy with improvement from baseline?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

****Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-157
Origination Date: 03/04/2022
Reviewed/Revised Date: 12/30/2024
Next Review Date: 12/30/2025
Current Effective Date: 01/01/2025

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
Kevzara for Polymyalgia Rheumatica®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for Pharmacy Customer Service for assistance at 385-425-5094

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested:

Preferred: corticosteroids, methotrexate
Non- formulary: ☐ Kevzara® (sarilumab)

Note: Kevazara for the indication of RA see PHARM-HCU-065

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Is the request made by a rheumatologist?	☐	☐	**Please provide documentation**
2. Does the member have a diagnosis of polymyalgia rheumatic (PMR)?	☐	☐	**Please provide documentation**
3. Has the member been taking prednisone for at least 8 weeks (≥10 mg/day or equivalent)?	☐	☐	**Please provide documentation**
4. Does the member have clinical documentation show at least one episode of an PMR flare while attempting to taper prednisone, including both of the following: • Shoulder and/or hip girdle pain associated with inflammatory stiffness • Erythrocyte sedimentation rate (ESR) ≥30 mm/hr and/or C-reactive protein (CRP) ≥ 10mg/L?	☐	☐	**Please provide documentation**
5. Has the member had an adequate trial and failure of methotrexate for at least 3 months?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the requesting for reauthorization of therapy?	☐	☐	

2. Does the member have clinical documentation show absence of signs and symptoms of PMR and CRP < 10 mg/L?	☐	☐	

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:

Physician Signature:

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-159
Origination Date: 01/02/2024
Reviewed/Revised Date: 01/29/2025
Next Review Date: 01/29/2026
Current Effective Date: 02/01/2025

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
PRURIGO NODULARIS
Dupixent®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred/Non-Formulary

1. Preferred
   A. Dupixent® (dupilumab)
2. Non-Formulary
   A. Nemluvio® (nemolizumab-ilto)

Product being requested:_____

Dosing/Frequency:_____

Note: for additional Dupixent indications please see the following:
for treatment of nasal polyps see PHARM-HCU-146 Chronic Rhinosinusitis with Nasal Polyposis (CRSwNP), for treatment of atopic dermatitis see PHARM-HCU-135 Atopic Dermatitis, for all other indications see PHARM-HCU-022

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Is the requesting provider a dermatologist, allergist or immunologist, or in consultation with one?	☐	☐	
2. Is the disease involvement rated as moderate to severe?	☐	☐	**Please provide documentation**
3. Does the member have at least 20 prurigo nodularis lesions in total on both legs, and/or both arms and/or trunk at time of this request?	☐	☐	**Please provide documentation**
4. Has the member tried phototherapy?	☐	☐	**Please provide documentation**
5. Has the member had an adequate trial with at least two moderate to very high potency prescription corticosteroids?	☐	☐	**Please provide documentation**
6. If unable to tolerate corticosteroids due to the treatment are (e.g. face, genitals, etc.), has the member had an adequate trial with a calcineurin inhibitor such as topical tacrolimus?	☐	☐	**Please provide documentation**

7. Has the member tried cyclosporine or methotrexate within the past 6 months?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Is there evidence of a positive clinical response to therapy?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:

Physician Signature:

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-160
Origination Date: 09/11/2024
Reviewed/Revised Date: 09/18/2024
Next Review Date: 09/18/2025
Current Effective Date: 10/01/2024

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
L-GLUTAMINE

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ L-glutamine

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Does the member have a diagnosis of sickle cell disease (SCD)?	☐	☐	**Please provide documentation**
2. Is the prescribing provider a physician who specializes in SCD (e.g. hematologist)?	☐	☐	
3. Has the member tried hydroxyurea for at least 3 months unless the member has a contraindication?	☐	☐	**Please provide documentation**
4. Will L-glutamine be used in combination with hydroxyurea, unless contraindicated or intolerant?	☐	☐	
5. Have preventative measures been discussed with the member including regular clinic visits, healthy diet and folic acid supplements, adequate hydration, avoiding extreme temperatures, and smoking cessation?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member had a positive response shown by an improvement in the incidence of VOC from baseline?	☐	☐	**Please provide documentation**
3. Has the member been consistently taking hydroxyurea, unless contraindicated or intolerant?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:
Physician Signature:

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy PHARM-HCU-161
Origination Date: 05/13/2020
Reviewed/Revised Date: 11/13/2024
Next Review Date: 11/13/2025
Current Effective Date: 12/01/2024

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
Eosinophilic Granulomatosis with Polyangiitis (EPGA)
Fasenra®, Nucala®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department.

- For **Medical Pharmacy** please fax requests to: 801-646-7300
- For **Retail Pharmacy** please fax requests to: 385-425-4052

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred/Non-Preferred

1. Preferred
    a. Fasenra® (benralizumab)
2. Non-Preferred
    a. Nucala® (mepolizumab)

Product being request: _____

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section			
Questions	**Yes**	**No**	**Comments/Notes**
1. Is the request made by, or in consultation with, a pulmonologist, rheumatologist, allergist, or immunologist?	☐	☐	
2. Does the member have a past medical history or presence of asthma?	☐	☐	**Please provide documentation**
3. Does documentation show blood eosinophil level of ≥10% or an absolute count >1000cells/mm^3?	☐	☐	**Please provide documentation**
4. Does the member have a confirmed diagnosis of EGPA with at least 2 of the following: • Neuropathy • Pulmonary infiltrates • Sinonasal abnormality • Cardiomyopathy • Glomerulonephritis • Alveolar hemorrhage • Antineutrophil cytoplasmic antibody (ANCA) positivity • Histopathologic evidence of eosinophilic vasculitis, perivascular eosinophilic	☐	☐	**Please provide documentation**

• Palpable purpura infiltration or eosinophil rich granulomatous inflammation			
5. Has the member been on a stable corticosteroid dose for at least 4 weeks prior to initiating the request therapy?	☐	☐	**Please provide documentation**
6. Has the member tried at least one of the following immunosuppressants used for maintenance therapy: azathioprine, methotrexate, or leflunomide?	☐	☐	**Please provide documentation**
7. Does documentation show objective baseline severity (e.g. nighttime awakenings, daytime symptoms, FEV1, etc.)?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does updated documentation show that the member has experienced a positive clinical response of at least one of the following: • reduction in the frequency and/or severity of relapses • reduction or discontinuation of doses of corticosteroids and/or immunosuppressants • disease remission • reduction in severity or frequency of EGPA-related symptoms	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician's Signature:			

****Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-163
Origination Date: 01/23/2025
Reviewed/Revised Date: 01/29/2025
Next Review Date: 01/29/2026
Current Effective Date: 02/01/2025

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
CHRONIC SPONTANEOUS URTICARIA
Dupixent®, Xolair®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department.

- For **Medical Pharmacy** please fax requests to: 801-646-7300
- For **Retail Pharmacy** please fax requests to: 385-425-4052

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred/Non-Preferred

1. Preferred
    a. Xolair® (omalizumab)
2. Non-Preferred
    a. Dupixent® (dupilumab)

Dosing/Frequency:_____

Note: for the treatment of nasal polyps see Chronic Rhinosinusitis with Nasal Polyposis (CRSwNP)

If the request is for reauthorization, proceed to reauthorization section			
Questions	**Yes**	**No**	**Comments/Notes**
1. Has the provider performed a medical evaluation that rules out other possible causes of urticaria?	☐	☐	**Please provide documentation**
2. Has the member had a trial and failure of an H1-antihistamine at up to four times standard dosing used in combination with an H2-antihistamine?	☐	☐	**Please provide documentation**
3. Has the member had a trial and failure of an H1-antihistamine used in combination with a leukotriene receptor antagonist or cyclosporine?	☐	☐	**Please provide documentation**
4. Is the request for dose escalation of Xolair®?	☐	☐	
5. For Dupixent®, does the member have a contraindication or intolerance to Xolair®?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	

2. Does clinical documentation show continued medical necessity and that the treatment has stabilized or improved the member's condition?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:

Physician's Signature:

****Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-164
Origination Date: 06/11/2025
Reviewed/Revised Date: 06/11/2025
Next Review Date: 06/11/2026
Current Effective Date: 07/01/2025

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
GIANT CELL ARTERITIS
Rinvoq®, Tyenne®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department.

- For **Medical Pharmacy** please fax requests to: 801-646-7300
- For **Retail Pharmacy** please fax requests to: 385-425-4052

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred/Non-Formulary:

1. 1st Line Preferred Agents:
    A. Tyenne® (tocilizumab-aazg)
2. Non-Preferred agents with single step; after trial and failure of a tocilizumab product:
    A. Rinvoq (upadacitinib)

Product being requested: _____

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Is the request being made by a rheumatologist?	☐	☐	
2. Does the member has a diagnosis of giant cell arteritis confirmed by biopsy or imaging?	☐	☐	**Please provide documentation**
3. Does the member has elevated levels of C-reactive protein (CRP) AND erythrocyte sedimentation rate (ESR)?	☐	☐	**Please provide documentation**
4. Is the member currently taking prednisone (or equivalent) ≥ 20mg once daily?	☐	☐	**Please provide documentation**
5. Is the member taking JAK inhibitors, biologic DMARDS, or potent immunosuppressants such as azathioprine and cyclosporine?	☐	☐	**Please provide documentation**

REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the therapy been tolerable?	☐	☐	**Please provide documentation**
3. Has the member had improvement in at least one symptom (e.g. headache, scalp or jaw pain, fatigue, vision)?	☐	☐	**Please provide documentation**
4. Has the member had improvement in CRP and/or ESR levels?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

****Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-165
Origination Date: 06/11/2025
Reviewed/Revised Date: 06/11/2025
Next Review Date: 06/11/2026
Current Effective Date: 07/01/2025

HEALTH | CHOICE
UTAH

PHARMACY PRIOR AUTHORIZATION REQUEST FORM
INTRAVENOUS IRON THERAPY
Feraheme®, Ferrlecit®, INFed®, Injectafer®, Monoferric®, Venofer®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 801-646-7300.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have medical pharmacy prior authorization questions, please call for assistance: 877-358-8797

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred: ☐ Feraheme® (ferumoxytol), ☐ INFed® (iron dextran), ☐ Venofer® (iron sucrose), ☐ Ferrlecit® (sodium ferric gluconate complex in sucrose)
Non-preferred: ☐ Injectafer® (ferric carboxymaltose), ☐ Monoferric® (ferric derisomaltose)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Does the member have a serum ferritin concentration ≤100ng/mL and one of the following diagnoses: • heart failure • chronic kidney disease(CKD) • hereditary hemorrhagic telangiectasia (HHT) • pregnant	☐	☐	**Please provide documentation**
2. Has the member been diagnosed with iron deficiency anemia?	☐	☐	**Please provide documentation**
3. Does documentation include laboratory work that shows blood counts and iron levels?	☐	☐	**Please provide documentation**
4. Has the member had a trial and failure to of oral iron therapy?	☐	☐	**Please provide documentation**
5. Is the member losing iron from blood loss at a rate greater than they are able to absorb from the intestine?	☐	☐	**Please provide documentation**
6. Does the member have a gastrointestinal disorder (e.g. ulcerative colitis, Crohn's disease) in which oral iron therapy may aggravate therapy?	☐	☐	**Please provide documentation**
7. Is the member unable to maintain iron balance on hemodialysis?	☐	☐	**Please provide documentation**
8. Is the member donating large amounts of blood for autotransfusion programs?	☐	☐	

9. Is the anemia chemotherapy-induced?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does documentation show a continued medical necessity and clinically significant response to therapy?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:

Physician's Signature:

****Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy PHARM-HCU-M002
Origination Date: 01/01/2022
Reviewed/Revised Date: 05/27/2025
Next Review Date: 05/27/2026
Current Effective Date: 06/01/2025

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
OPHTHALMIC INJECTIONS

Avastin®,Beovu®, Byooviz™, Cimerli™, Eylea®, Lucentis®, Macugen®, Susvimo™, Syforve™, Vabysmo™

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 801-646-7300.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have medical pharmacy prior authorization questions, please call for assistance: 877-358-8797

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred: ☐ Avastin® (bevacizumab) prior authorization not required, ☐ Byooviz™ (ranibizumab-nuna), ☐ Cimerli™ (ranibizumab-eqrn), ☐ Eylea® (aflibercept)
Non-preferred: ☐ Beovu® (brolucizumab-dbll), ☐ Lucentis® (ranibizumab), ☐ Macugen® (pegaptanib), ☐ Susvimo™ (ranibizumab implant), ☐ Syforve™ (pegcetacoplan), ☐ Vabysmo™ (faricimab-svoa)
*preferred first line, **preferred second line, ***preferred third line

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Is the member 18 years of age or older?	☐	☐	
2. Is the requesting provider an ophthalmologist or in consultation with one?	☐	☐	
3. Does the member have a diagnosis of diabetic macular edema (DME), diabetic retinopathy (DR) in patients with DME, age-related macular edema (AMD), myopic choroidal neovascularization (mCNV), or macular edema following a retinal vein occlusion (RVO)?	☐	☐	**Please provide documentation**
4. Does the member have a baseline visual acuity score?	☐	☐	**Please provide documentation**
5. For Beovu®, does documentation show a trial and failure of Avastin® and Eylea®?	☐	☐	**Please provide documentation**
6. For Byooviz™, does documentation show a diagnosis of AMD, RVO or mCNV and a trial and failure of Avastin® and Eylea®?	☐	☐	**Please provide documentation**
7. For Cimerli™, does documentation show a diagnosis of DME or DR and trial and failure of Avastin® and Eylea®?	☐	☐	**Please provide documentation**
8. For Eylea®, does documentation show a trial and failure of Avastin®?	☐	☐	**Please provide documentation**

9. For Lucentis®, does documentation show a trial and failure of Avastin®, Byooviz™ or Cimerli™, and Eylea®?	☐	☐	**Please provide documentation**
10. For Macugen®, does documentation show a trial and failure of Avastin®, Byooviz™ or Cimerli™, and Eylea®?	☐	☐	**Please provide documentation**
11. For Susvimo™, does documentation show a trial and failure of Avastin®, Byooviz™ or Cimerli™, and Eylea®?	☐	☐	**Please provide documentation**
12. For Syforve™, does the member have a best corrected visual acuity score and a diagnosis of geographic atrophy of the macula secondary to age-related macular degeneration?	☐	☐	**Please provide documentation**
13. For Vabysmo™, does documentation show a trial and failure of Avastin®, Byooviz™ or Cimerli™, and Eylea®?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Do updated clinical notes show a positive response to therapy and a continued medical necessity?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician's Signature:			

****Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy PHARM-HCU-M005
Origination Date: 01/01/2022
Reviewed/Revised Date: 07/29/2024
Next Review Date: 07/29/2025
Current Effective Date: 08/01/2024

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
PROLIA®, XGEVA®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 801-646-7300.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have medical pharmacy prior authorization questions, please call for assistance: 877-358-8797

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Prolia® (denosumab), ☐ XGEVA® (denosumab)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
PROLIA® FOR OSTEOPROSIS			
1. Has the member been diagnosed with osteoporosis?	☐	☐	**Please provide documentation**
2. Does the member have a documented baseline bone mineral density (BMD) T-score of ≤ -2.5 by DEXA scan?	☐	☐	**Please provide documentation**
3. Has the member had a 24-month trial and failure to a bisphosphonate?	☐	☐	**Please provide documentation**
PROLIA® FOR BONE LOSS SECONDARY TO AROMATASE INHIBITORS			
1. Has the member been diagnosed with breast cancer and is currently taking an aromatase inhibitor?	☐	☐	**Please provide documentation**
2. Does the member have a documented baseline bone mineral density (BMD) T-score of < -1.0 by DEXA scan?	☐	☐	**Please provide documentation**
3. Has the member had a 24-month trial and failure with a bisphosphonate?	☐	☐	**Please provide documentation**
PROLIA® FOR HORMONE- SENSITIVE PROSTATE CANCER			
1. Has the member been diagnosed with Hormone-Sensitive Prostate Cancer and currently taking androgen deprivation therapy?	☐	☐	**Please provide documentation**
2. Does the member have a FRAX score of 10 year probability of hip fracture >3% or a 10 year probability of major osteoporosis-related fracture of >20%?	☐	☐	**Please provide documentation**

3. Has the member had a 24-month trial and failure to a bisphosphonate?	☐	☐	**Please provide documentation**
XGEVA®			
1. Has the member been diagnosed with giant cell tumor of bone that is unresectable or where surgical resection is likely to result in severe morbidity?	☐	☐	**Please provide documentation**
2. Does the member have a diagnosis of metastatic bone disease from solid tumor and has had a trial and failure to a bisphosphonate?	☐	☐	**Please provide documentation**
3. Has the member been diagnosed with hypercalcemia of malignancy refractory to bisphosphonate therapy?	☐	☐	**Please provide documentation**
4. Has the member had a trial and failure of an intravenous bisphosphonate, unless contraindicated?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member's therapy been re-evaluated within the past 12 months?	☐	☐	
3. Has the therapy shown to be effective with an improvement or stabilization in condition?	☐	☐	**Please provide documentation**
4. Does the member have a continued medical need for the therapy?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician's Signature:			

****Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy PHARM-HCU-M006
Origination Date: 01/01/2022
Reviewed/Revised Date: 12/30/2024
Next Review Date: 12/30/2025
Current Effective Date: 01/01/2025

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
SPINRAZA®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 801-646-7300.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have medical pharmacy prior authorization questions, please call for assistance: 877-358-8797

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Spinraza® (nusinersen)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Does the member have a diagnosis of spinal muscular atrophy (SMA) type 1, 2 or 3?	☐	☐	**Please provide documentation**
2. Is the requesting provider a neurologist with expertise in spinal muscular atrophy?	☐	☐	
3. Does clinical documentation show one of the following: • 5q SMA homozygous gene deletion or mutation • Compound heterozygote mutation	☐	☐	**Please provide documentation**
4. Is the member ≤15 years of age?	☐	☐	
5. Is the member dependent on either invasive ventilation or tracheostomy?	☐	☐	
6. Does documentation contain a baseline platelet count?	☐	☐	**Please provide documentation**
7. Does documentation include at least one of the following baseline motor ability scores: • Hammersmith Infant Neurological Exam (HINE) • Hammersmith Functional Motor Scale Expanded (HFMSE) • Upper Limb Module Test (non-ambulatory) • Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND)	☐	☐	**Please provide documentation**
8. Has the member received treatment with Zolgensma®?	☐	☐	**Please provide documentation**
9. Does clinical documentation show trial and failure or contraindication/intolerance to Evrysdi® (risdiplam)?	☐	☐	**Please provide documentation**

10. Is member currently taking Evrysdi® (risdiplam) or are there plans to start Evrysdi® (risdiplam)?			
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member's therapy been re-evaluated within the past 7 months?	☐	☐	
3. Does the member meet initial authorization criteria?	☐	☐	**Please provide documentation**
4. Has the member received treatment with Zolgensma®?	☐	☐	**Please provide documentation**
5. Does documentation show platelet counts prior to each dose?	☐	☐	**Please provide documentation**
6. Has the member responded to therapy with documentation showing maintenance or improvement in motor milestones?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician's Signature:			

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-M007
Origination Date: 01/01/2022
Reviewed/Revised Date: 03/18/2025
Next Review Date: 03/18/2026
Current Effective Date: 04/01/2025

HEALTH | CHOICE
UTAH

PHARMACY PRIOR AUTHORIZATION REQUEST FORM
TESTOPEL®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 801-646-7300.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have medical pharmacy prior authorization questions, please call for assistance: 877-358-8797

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Testopel® (testosterone pellets)

Please note that testosterone injectable and topical testosterone are the plans preferred products.

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.			
Questions	**Yes**	**No**	**Comments/Notes**
1. Is the member 18 years of age or older?	☐	☐	
2. Is the member male?	☐	☐	
3. Does the member have a confirmed diagnosis of one of the following? • Primary hypogonadism • Hypogonadotropic hypogonadism	☐	☐	**Please provide documentation**
4. Does the member have 2 confirmed early morning low serum testosterone levels at least 24 hours apart, defined as one of the following: • Total testosterone(TT) <464ng/dL (9.2nmol/L) for CDC certified TT assays • Free testosterone (FT) level less than the laboratory's normal reference range	☐	☐	**Please provide documentation**
5. Has the member had at least a 6-month trial and failure of injectable testosterone?	☐	☐	**Please provide documentation**
6. Has the member had at least a 6-month trial and failure of topical testosterone?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the requesting for reauthorization of therapy?	☐	☐	

2. Does clinical documentation show continued medical necessity and that the treatment is effective?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.
Additional information:
Physician Signature:

****Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy PHARM-HCU-M008
Origination Date: 01/01/2022
Reviewed/Revised Date: 11/13/2024
Next Review Date: 11/13/2025
Current Effective Date: 12/01/2024

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
ZILRETTA®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 801-646-7300.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have medical pharmacy prior authorization questions, please call for assistance: 877-358-8797

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Zilretta® (triamcinolone acetonide extended release injectable suspension)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Is the member 18 years of age or older?	☐	☐	
2. Does the member have a BMI ≤40?	☐	☐	
3. Is the prescription written by or in consultation with a sports medicine physician, physical medicine and rehabilitation physician, rheumatologist, orthopedist, or pain management specialist?	☐	☐	
4. Does the member have a diagnosis of grade II or grade III primary osteoarthritis of the knee?	☐	☐	**Please provide documentation**
5. Does the member have a diagnosis of grade IV osteoarthritis of the knee and is contraindicated for a total knee replacement?	☐	☐	**Please provide documentation**
6. Is the member experiencing moderate to severe functional impairment with at least one of the following: • Functional impairment with poor mobility • Increased pain with prolonged standing • Frequent flares requiring use of analgesics or NSAIDs, corticosteroids, etc.	☐	☐	**Please provide documentation**
7. Has the member had a trial and failure of ALL of the following: • Physician directed exercise or a physical therapy program • Simple analgesics such as acetaminophen and/or topical capsaicin AND prescription strength NSAIDs for at least 3 months	☐	☐	**Please provide documentation**

• Orthotic device like a knee brace • History of a positive but inadequate response to at least one other intra-articular glucocorticoid injection of the knee			
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

****Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy PHARM-HCU-M010
Origination Date: 01/01/2022
Reviewed/Revised Date: 05/27/2025
Next Review Date: 05/27/2026
Current Effective Date: 06/01/2025

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
XIAFLEX®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 801-646-7300.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have medical pharmacy prior authorization questions, please call for assistance: 877-358-8797

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Xiaflex® (collagenase clostridium histolyticum)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
DUPUYTREN'S CONTRACTURE			
1. Does the member have a confirmed diagnosis of Dupuytren's contracture with palpable cord of at least one finger?	☐	☐	**Please provide documentation**
2. Is the member 18 years of age or older?	☐	☐	
3. Does the palpable cord involve the metacarpophalangeal (MP) joint or the proximal interphalangeal (PIP) joint?	☐	☐	**Please provide documentation**
4. Has the member had a fasciectomy or fasciotomy within 90 days prior to the first injection?	☐	☐	**Please provide documentation**
PEYRONIE'S DISEASE			
1. Does the member have a confirmed diagnosis of Peyronie's disease with palpable plaque?	☐	☐	**Please provide documentation**
2. Is the member 18 years of age or older?	☐	☐	
3. Is the prescribing provider an urologist?	☐	☐	
4. Does member have a curvature deformity of at least 30 degrees at the start of therapy?	☐	☐	**Please provide documentation**
5. Is the curvature deformity caused by congenital ventral penile curvature or curvature associated with epispadias?	☐	☐	**Please provide documentation**
6. Is member experiencing clinical complications from Peyronie's such as pain and/or difficulty with urination?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
DUPUYTREN'S CONTRACTURE			

1. Does the member meet the initial criteria?	☐	☐	**Please provide documentation**
2. Does documentation show the MP or PIP contracture remains?	☐	☐	**Please provide documentation**
3. Was the last treatment ≥ 4 weeks ago?	☐	☐	**Please provide documentation**
4. Has the member received > 3 injections per cord?	☐	☐	**Please provide documentation**
PEYRONIE'S DISEASE			
1. Does documentation show that a maximum of 4 treatment cycles have been received?	☐	☐	**Please provide documentation**
2. Is the member experiencing clinical complications from Peyronie's such as pain and/or difficulty with urination?	☐	☐	**Please provide documentation**
3. Does documented curvature deformity remain at ≥ 15 degrees since the last treatment cycle?	☐	☐	**Please provide documentation**
4. Do clinic notes document that a penile modeling procedure has been performed 1 to 3 days after each injection?	☐	☐	**Please provide documentation**
5. Was the last treatment cycle ≥ 6 weeks ago?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

****Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy PHARM-HCU-M011
Origination Date: 01/01/2022
Reviewed/Revised Date: 03/18/2025
Next Review Date: 03/18/2026
Current Effective Date: 04/01/2025

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
Atypical Hemolytic Uremic Syndrome
Soliris®, Ultomiris®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 801-646-7300.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have medical pharmacy prior authorization questions, please call for assistance: 877-358-8797

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Soliris® (eculizumab), ☐ Ultomiris® (ravilizumab)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Does the member have a diagnosis of Atypical Hemolytic Uremic Syndrome (aHUS)?	☐	☐	
2. Has Shiga toxin-related hemolytic uremic syndrome been ruled out?	☐	☐	**Please provide documentation**
3. Does the member have a normal ADAMTS-13 level?	☐	☐	**Please provide documentation**
4. Has the member had the Neisseria meningitidis vaccination?	☐	☐	**Please provide documentation**
5. Is the prescribing physician enrolled in Soliris® or Ultomiris® REMS program?	☐	☐	
6. If the request is for Soliris®, has the member tried and failed Ultomiris®, unless contraindicated?	☐	☐	**Please provide documentation**
1. Is there documentation of an Expanded Disability Status Score (EDSS) of ≤8?	☐	☐	**Please provide documentation**
2. Has the member had an adequate trial and failure of Enspryng®, Ruxience® AND Uplizna™?	☐	☐	**Please provide documentation**
3. Is the prescribing physician enrolled in Soliris® REMS program?	☐	☐	
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has a clinically significant response been demonstrated (e.g. decrease in LDH, improvement in SCr/eGFR, increase in platelet count, or decrease in plasmapheresis frequency from baseline)?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.
Additional information:
Physician's Signature:

****Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-068
Origination Date: 01/01/2022
Reviewed/Revised Date: 06/11/2025
Next Review Date: 06/11/2026
Current Effective Date: 07/01/2025

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
BRINEURA

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 801-646-7300.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have medical pharmacy prior authorization questions, please call for assistance: 877-358-8797

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Brineura® (cerliponase alfa)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.			
Questions	**Yes**	**No**	**Comments/Notes**
1. Is the member between 3 to 16 years of age?	☐	☐	
2. Is the member seen and followed by a neurologist/pediatric neurologist who is familiar with treatment of Batten disease?	☐	☐	
3. Does the member have a documented diagnosis of late infantile neuronal ceroid lipofuscinosis type 2 confirmed by TPP1 deficiency and/or a dysfunctional mutation of the TTP1 gene on chromosome 11p15?	☐	☐	**Please provide documentation**
4. Does documentation show a two-domain score of 3 to 6 on motor and language domains of the Hamburg CLN2 Clinical Rating Scale, with a score of at least 1 in each of these domains at the time of request?	☐	☐	**Please provide documentation**
5. Is the member ambulatory?	☐	☐	
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does the member meet initial authorization criteria?	☐	☐	
3. Has the member experienced unacceptable toxicity to the therapy?	☐	☐	**Please provide documentation**
4. Have CSF testing within the past 3 months been documented?	☐	☐	**Please provide documentation**
5. Has the member had a clinically significant response to the therapy with a stability/lack of decline in motor	☐	☐	**Please provide documentation**

function/milestones on the motor domain of the Hamburg CLN2 Clinical Rating Scale?			
6. Has the member had a 12-lead ECG performed within the last 6 months?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-M014
Origination Date: 01/01/2022
Reviewed/Revised Date: 04/09/2025
Next Review Date: 04/09/2026
Current Effective Date: 05/01/2025

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
TEPEZZA™

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 801-646-7300.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have medical pharmacy prior authorization questions, please call for assistance: 877-358-8797

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Tepezza™ (teprotumumab-trbw)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Is the member 18 years of age or older?	☐	☐	
2. Is the prescriber an ophthalmologist?	☐	☐	
3. Does the member have a diagnosis of Graves' disease?	☐	☐	**Please provide documentation**
4. Does the member have a diagnosis of active moderate to severe Thyroid Eye Disease with clinical complications? • Low disease activity is excluded	☐	☐	**Please provide documentation**
5. Did ocular symptoms begin within 9 months of the baseline assessment?	☐	☐	**Please provide documentation**
6. Is the member's condition moderate to severe as evidenced by one or more of the following: • Lid retraction > 2 mm • Moderate to severe soft-tissue involvement • Proptosis ≥ 3 mm above the normal value for race and sex • Periodic or constant diplopia	☐	☐	**Please provide documentation**
7. Is the member euthyroid?	☐	☐	**Please provide documentation**
8. Does the provider attest that smoking cessation has been addressed with the member?	☐	☐	
9. Has the member had a 1-month trial and failure or contraindication/intolerance to systemic corticosteroids at the maximum tolerated dose?	☐	☐	**Please provide documentation**

10. For members with reproductive potential: Does the provider attest the member is not pregnant and has been informed that appropriate forms of contraception should be implemented prior to initiation, during treatment and for 6 months following the last dose of Tepezza™?	☐	☐	
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

****Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy PHARM-HCU-M016
Origination Date: 01/01/2022
Reviewed/Revised Date: 11/13/2024
Next Review Date: 11/13/2025
Current Effective Date: 12/01/2024

Place of Service for Pharmaceutical Infusions

Policy: PHARM-HCU-M026

Origination Date: 01/01/2022

Reviewed/Revised Date: 04/09/2025

Next Review Date: 04/09/2026

Current Effective Date: 05/01/2025

Disclaimer:

1. Policies are subject to change in accordance with Federal and State notice requirements.
2. Policies outline coverage determinations for Healthy U CHIP. Refer to the "Policy" and "Lines of Business" section for more information.
3. Services requiring prior-authorization may not be covered, if the prior-authorization is not obtained.
4. This Pharmacy Policy does not guarantee coverage or payment of the service. The service must be a benefit in the member's plan and the member must be eligible for coverage at the time of service. Additional payment guidelines may be applied that are not included in this policy.

Purpose

This policy is to establish place of service determinations for Pharmaceutical Infusion Therapy. Health Choice Utah requires intravenous (IV) infusion therapy will be covered in the most appropriate, safe, and cost effective site. Sites of care include hospital inpatient, hospital outpatient, community office, ambulatory infusion suite, or home-based setting. These different service sites may cause escalating costs to members. In the interest of reducing member and plan costs, these services may be redirected by the plan to the lowest safe site of service.

Policy/Coverage

1. **Coverage Criteria**
    - A. **Health Choice Utah will provide pharmaceutical infusion coverage when it is determined to be medically necessary based on Health Plan Criteria.**
    - B. **Health Choice Utah requires certain intravenous (IV) infusion therapy to be administered at a preferred vendor and at a preferred site of care.**
    - C. **Pharmaceutical infusion therapy delivered in an outpatient setting (e.g., home infusion, ambulatory infusion centers, provider office) is the preferred place of service for medical infusions UNLESS a hospital-based setting (inpatient or outpatient) is considered medically necessary.**
    - D. **Medical necessity of a hospital-based setting may be established if the member meets ONE of the following criteria:**
        - i. Member is ≤ 13 years of age

ii. Member is medically unstable per clinical documentation
iii. Medication has a high risk of immediate life-threatening toxicities (i.e., anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure)
iv. Member has a history of mild adverse events that have NOT been successfully managed with pre-medications such as antihistamines, corticosteroids, or intravenous fluids
v. Member has co-morbidities that place them at increased risk for severe adverse events (i.e. unstable renal function, cardiopulmonary conditions, unstable vascular access)
vi. First infusion of therapy with moderate to high potential for adverse event
vii. Infusion with moderate to high potential for adverse event and it has been > 6 months since last infusion
viii. If there is no outpatient infusion center within 50 miles of the member's home and there is no contracted home infusion agency that will travel to their home
ix. If a hospital is the only place that offers infusion of this drug.

E. **When Pharmaceutical infusion is not covered:**
i. Inpatient and hospital outpatient infusion, in the absence of the clinical indications above, is **NOT** considered medically necessary.
ii. An inpatient admission for the sole purpose of IV infusion is not medically necessary.

References:

1. AAAAI Guidelines for the site of care for administration of IGIV therapy (2011)
2. ASPEN Parenteral Nutrition Safety Consensus Recommendations (2013)
3. IDSA Practice Guidelines for Outpatient Parenteral Antimicrobial Therapy (OPAT, 2018)
4. Lexicomp®Online Database http://online.lexi.com.ezproxy.lib.utah.edu/lco/action/home
5. United Healthcare® Oxford Clinical Policy; Provider Administered Drugs – Site of Care. Effective date 6/1/2021; Accessed 07/01/2022.

Date	Review, Revisions, Approvals
01/01/2022	Health Choice Utah policy created.
07/07/2022	Completed annual review of policy.
07/22/2022	Policy reviewed and approved by the P&T Committee via e-vote. Policy effective 08.01.2022
06/12/2024	Policy reviewed for annual update
04/09/2025	Policy reviewed and approved by P&T Committee. Effective date 05.01.2025

The codes for treatments and procedures applicable to this policy are included for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Health Choice Utah makes no representations and accepts no liability with respect to the content of any external information cited or relied upon in this policy. Health Choice Utah updates its Coverage Policies regularly, and reserves the right to amend these policies and give notice in accordance with State and Federal requirements.

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
Neuromyelitis Optica Spectrum Disorder (NMOSD)
Enspryng ®, Ruxience ®, Soliris®, Uplizna™, Ultomiris®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 801-646-7300.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have medical pharmacy prior authorization questions, please call for assistance: 877-358-8797

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Enspryng ® (satralizumab), ☐ Ruxience ® (rituximab-pvvr), ☐ Soliris® (eculizumb), ☐ Uplizna™ (inebilizumab-cdon), ☐ Ultomiris® (ravulizumab-cwvz)

A. Enspryng®
   i. Documentation must show that the member has had an adequate trial and failure of a rituximab product before a request for Enspryng ® may be considered.

B. Uplizna®
   i. Documentation must show that the member has had an adequate trial and failure of a rituximab product and Enspryng ® before a request for Uplizna® may be considered.

C. Ultomiris®
   i. Documentation must show that the member has had an adequate trial and failure of Enspryng®, a rituximab product and Uplizna® before a request for Ultomiris® may be considered.
      a. Note: Members that have had a severe breakthrough on a rituximab product will be exempt from the trial of Uplizna®

D. Soliris®
   i. Documentation must show that the member has had an adequate trial and failure of Enspryng®, a rituximab product, Ultomiris® and Uplizna® before a request for Soliris®® may be considered.
      a. Note: Members that have had a severe breakthrough on a rituximab product will be exempt from the trial of Uplizna®

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Is the request made by, or in consultation with, a specialist in the treatment of neuromyelitis optica spectrum disorder (NMOSD)?	☐	☐	
2. Does the member have a confirmed diagnosis of NMOSD with positive AQP-4 antibodies and at least one core clinical characteristic such as: optic neuritis, acute myelitis, area	☐	☐	**Please provide documentation**

postrema syndrome, acute brainstem syndrome, symptomatic narcolepsy, acute diencephalic clinical syndrome, or symptomatic cerebral syndrome with brain lesions?			
3. Is an Expanded Disability Status Scare (EDSS) score equal to 8 or less?	☐	☐	**Please provide documentation**
4. Has the member had at least 1 relapse that required rescue therapy in the last 12 months or 2 or more relapses that required rescue therapy in the last 24 months?	☐	☐	**Please provide documentation**
5. Has the member had an adequate trial and failure of any of the medications listed in this policy?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does documentation show a clinically significant response to therapy demonstrated by one of the following: • Decrease in relapse rate • Improvement of symptoms or stabilization of symptoms associated with relapse • Improvement in EDSS score	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

****Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-M027
Origination Date: 01/01/2022
Reviewed/Revised Date: 09/18/2024
Next Review Date: 09/18/2025
Current Effective Date: 10/01/2024

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
AKYNZEO® IV

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 801-646-7300.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have medical pharmacy prior authorization questions, please call for assistance: 877-358-8797

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Akynzeo® (fosaprepitant/palonosetron) IV

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section			
Questions	**Yes**	**No**	**Comments/Notes**
1. Is this request for prevention of acute and delayed nausea and vomiting associated with initial and repeat courses of highly emetogenic intravenous chemotherapy?	☐	☐	**Please provide documentation**
2. Is the request for prevention of acute and delayed nausea and vomiting associated with initial and repeat courses of moderately emetogenic intravenous chemotherapy? Documentation must show previous treatment failure, intolerance, contraindication, to a steroid + 5HT3 RA + olanzapine OR clinical reasoning as to why NK-1 RA is needed.	☐	☐	**Please provide documentation**
3. Has the member tried and failed aprepitant and fosaprepitant in combination with palonosetron?	☐	☐	**Please provide documentation**
4. Is the request for the prevention of nausea and vomiting associated with anthracycline plus cyclophosphamide (AC) chemotherapy? Documentation must show medical necessity.	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does documentation show the therapy was effective with a positive clinical response to therapy?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.
Additional information:
Physician Signature:

****Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-M028
Origination Date: 01/01/2022
Reviewed/Revised Date: 12/30/2024
Next Review Date: 12/30/2025
Current Effective Date: 01/01/2025

HEALTH | CHOICE
UTAH

PHARMACY PRIOR AUTHORIZATION REQUEST FORM
KRYSTEXXA®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 801-646-7300.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have medical pharmacy prior authorization questions, please call for assistance: 877-358-8797

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Krystexxa® (pegloticase)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Is the prescribing provider a rheumatologist?	☐	☐	
2. Does documentation show a diagnosis of chronic gout with hyperuricemia?	☐	☐	**Please provide documentation**
3. Does documentation demonstrate one of the following: • 3 or more gout flares in the previous 18 months • 1 or more tophus • Presence of chronic gouty arthritis?	☐	☐	**Please provide documentation**
4. Has the member undertaken lifestyle modifications, such as weight loss for obese individuals (weight control) or avoidance of, or limiting, alcohol consumption or dietary intake of meats and fish high in purine content?	☐	☐	**Please provide documentation**
5. Does documentation show a baseline serum uric acid level > 8mg/dL?	☐	☐	**Please provide documentation**
6. Has the member failed, or is contraindicated/intolerant to, at least a 6-month trial of maximum tolerated FDA-approved doses of allopurinol and febuxostat?	☐	☐	**Please provide documentation**
7. For members with African American or Mediterranean ancestry, has the member been screened and found negative for G6PD deficiency?	☐	☐	**Please provide documentation**

8. Will Krystexxa® be given in combination with weekly methotrexate 15 mg orally? Krystexxa® alone may only be used in patients for whom methotrexate is contraindicated or not clinically appropriate.	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does clinical documentation show an improvement or stabilization of the condition?	☐	☐	**Please provide documentation**
3. Does documentation show a recent uric acid level of < 6 mg/dL?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

****Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-M029
Origination Date: 01/01/2022
Reviewed/Revised Date: 11/13/2024
Next Review Date: 11/13/2025
Current Effective Date: 12/01/2024

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
VYEPTI™

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 801-646-7300.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have medical pharmacy prior authorization questions, please call for assistance: 877-358-8797

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Vyepti™ (eptinezumab)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Does the member have a diagnosis of episodic or chronic migraines?	☐	☐	**Please provide documentation**
2. Has the member has a 3-month trial and failure, contraindication, or intolerance to a beta-blocker, Botulinum toxin type A, and at least 1 of the following: • A calcium channel blocker • An antidepressant • An anticonvulsant • An angiotensin-converting enzyme (ACE) inhibitor **Note:** if the member cannot try a beta-blocker, then 2 migraine prevention medication classes listed above must be tried.	☐	☐	**Please provide documentation**
3. Has the member tried and failed, or is contraindicated to, preferred agents Ajovy®, Emgality®, and Aimovig®?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does clinical documentation show a positive response to therapy?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:
Physician Signature:

****Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-M032
Origination Date: 01/01/2022
Reviewed/Revised Date: 04/09/2025
Next Review Date: 04/09/2026
Current Effective Date: 05/01/2025

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
PRIMARY HYPEROXALURIA TYPE 1

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 801-646-7300.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have medical pharmacy prior authorization questions, please call for assistance: 877-358-8797

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Oxlumo™ (lumasiran), ☐ Rivfloza™ (nedosiran)
Please note: the preferred medication will be determined based on Medical Necessity Assessment

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Is the request made by, or in consultation with, a physician who specializes in the treatment of primary hyperoxaluria type 1 (PH1)?	☐	☐	
2. Does the member have a diagnosis of PH1 confirmed by both of the following: • Metabolic testing shows elevated urinary oxalate excretion persistently > 0.7mmol/1.73m^2/day OR for those less than 6 years of age a urinary oxalate/serum creatinine ratio > the ULN for the member's age • Genetic testing confirms a mutation in the alanine glyoxylate aminotransferase (AGXT) gene	☐	☐	**Please provide documentation**
3. Has the member received a liver transplant?	☐	☐	
4. Does the member have an estimated glomerular filtration rate (eGFR) > 30mL/min/1.73m^2?	☐	☐	**Please provide documentation**
5. Has the prescriber educated the member about diet, such as avoiding oxalate rich foods (e.g. chocolate, leafy green vegetables, black teas, nuts, star fruit)?	☐	☐	**Please provide documentation**
6. Has the member tried and failed, or has a contraindication/intolerance to, large fluid intake resulting in a high urinary output (> 3 L/day/1.73m^2)?	☐	☐	**Please provide documentation**

7. Has the member tried and failed, is currently taking, or has a contraindication/intolerance to, calcium-oxalate crystallization inhibitors (e.g. potassium citrate-citric acid, orthophosphate, magnesium oxide)?	☐	☐	**Please provide documentation**
8. Has the member tried and failed, is currently taking, or has a contraindication/intolerance to, pyridoxine (Vitamin B6) for ≥ 3 months without a positive response (defined as a reduction of > 30% in urinary oxalate excretion)?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member had a positive response to therapy with a significant reduction from baseline in urinary oxalate levels or for those <6 years of age a decrease in urinary oxalate/serum creatinine ratio?	☐	☐	**Please provide documentation**
3. Has the member experienced unacceptable drug toxicity to therapy?	☐	☐	
4. Has the member received a liver transplant?	☐	☐	
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

****Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy PHARM-HCU-M035
Origination Date: 01/01/2022
Reviewed/Revised Date: 03/27/2024
Next Review Date: 03/27/2025
Current Effective Date: 04/01/2024

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
KETAMINE

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 801-646-7300.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have medical pharmacy prior authorization questions, please call for assistance: 877-358-8797

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred: ☐ ketamine intravenous injection

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
KETAMINE			
1. Does the member have a diagnosis of moderate to severe major depressive disorder?	☐	☐	**Please provide documentation**
2. Is the member taking an antidepressant and will treatment with an antidepressant continue while taking ketamine?	☐	☐	**Please provide documentation**
3. Has the member had an inadequate response to at least an 8-week trial of the maximum tolerated dose of three different classes of antidepressants?	☐	☐	**Please provide documentation**
4. Does the member have a recent history of substance abuse or alcohol use disorder?	☐	☐	
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has member been compliant with their primary antidepressant if applicable?	☐	☐	**Please provide documentation**
3. Does clinical documentation show a continued medical necessity and a positive clinical response?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:
Physician Signature:

****Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-M036
Origination Date: 01/01/2022
Reviewed/Revised Date: 01/29/2025
Next Review Date: 01/29/2026
Current Effective Date: 02/01/2025

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
SAPHNELO™

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 801-646-7300.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have medical pharmacy prior authorization questions, please call for assistance: 877-358-8797

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Saphnelo™ (anifrolumab-fnia)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
MODERATE TO SEVERE SYSTEMIC LUPUS ERYTHEMATOSUS (SLE)			
1. Does the member have a diagnosis of moderate to severe systemic lupus erythematosus (SLE)?	☐	☐	**Please provide documentation**
2. Have laboratory tests been completed indicating the presence of autoantibodies (ANA, Anti-dsDNA, Anti-Sm, Anti-Ro/SSA, Anti-La/SSB)?	☐	☐	**Please provide documentation**
3. Is the requesting provider a rheumatologist or in consultation with a rheumatologist?	☐	☐	**Please provide documentation**
4. Does the member have a Systemic Lupus Erythematosus Disease Activity Index 2000 (SLEDAI-2K) score of ≥ 6 points?	☐	☐	**Please provide documentation**
5. Does the member have a contraindication, intolerance or failure to Benlysta®?	☐	☐	**Please provide documentation**
6. Is the member receiving Saphnelo™ in combination with a biologic agent, Benlysta® or cyclophosamide?	☐	☐	**Please provide documentation**
7. Does the member have active musculoskeletal or cutaneous disease that is unresponsive to standard therapy with glucocorticoids, antimalarials and/or other immunosuppressive agents?	☐	☐	**Please provide documentation**
8. Does the member have corticosteroid-dependent disease (prednisone equivalent dose ≥7.5mg/day) or trialed and failed both of the following: • hydroxychloroquine AND	☐	☐	**Please provide documentation**

• at least 1 immunosuppressant (e.g., azathioprine, methotrexate, mycophenolate, cyclosporine, cyclophosphamide)			
9. Is the member at least 80% compliant for at least 6 months with their baseline therapy (i.e. glucocorticoids, immunosuppressants and/or antimalarials)?	☐	☐	**Please provide documentation**
10. Will the member use Saphnelo™ concurrently with baseline therapy, unless the member has a contraindication or intolerance to all?	☐	☐	**Please provide documentation**
11. Does the member have severe active lupus nephritis or severe active central nervous system lupus (e.g., generalized seizures, psychosis, stroke, peripheral neuropathies)?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member shown a positive clinical response to therapy?	☐	☐	**Please provide documentation**
3. Has the member been compliant with baseline therapy during Saphnelo™ administration, unless otherwise contraindicated?	☐	☐	**Please provide documentation**
4. Is the member receiving Saphnelo™ in combination with a biologic agent or Benlysta®?	☐	☐	**Please provide documentation**
5. Does the member have severe active central nervous system lupus or severe active lupus nephritis?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

****Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-M037
Origination Date: 12/02/2021
Reviewed/Revised Date: 04/09/2025
Next Review Date: 04/09/2026
Current Effective Date: 05/01/2025

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
CARVYKTI™

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 801-646-7300.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have medical pharmacy prior authorization questions, please call for assistance: 877-358-8797

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Carvykti™ (ciltacabtagene autoleucel)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
RELAPSED OR REFRACTORY MULTIPLE MYELOMA			
1. Is the request made by an oncologist?	☐	☐	**Please provide documentation**
2. Is the member 18 years of age or older?	☐	☐	**Please provide documentation**
3. Does the member have a diagnosis of multiple myeloma with measurable disease including at least one of the following: • Serum monoclonal paraprotein (M-protein) ≥ 1 g/dL • Urine M-protein ≥ 200 mg/24 hours • Serum immunoglobulin free light chain (FLC) assay ≥ 10 mg/dL and abnormal serum immunoglobulin kappa lambda free light chain ratio	☐	☐	**Please provide documentation**
4. Does the member have relapsed or refractory disease, defined as progression after ≥ 4 lines of systemic therapy and includes all of the following: • Proteasome inhibitor (e.g., ixazomib, bortezomib, or carfilzomib) • Anti-CD38 antibody (e.g., isatuximab or daratumumab) • Immunomodulatory agent (e.g., thalidomide, pomalidomide, lenalidomide)	☐	☐	**Please provide documentation**
5. Does the member have an Eastern Cooperative Oncology Group (ECOG) grade of 0 or 1?	☐	☐	**Please provide documentation**
6. Does the member have adequate hematology markers defined by all of the following:			

• Platelet count ≥ 50,000 cells/uL • Absolute Neutrophil Count ≥ 750 cells/uL • Hemoglobin ≥ 8.0 g/dL			
7. Does the member have any of the following: • Hepatic transaminases > 3 times the upper limit of normal • Creatinine clearance < 40 mL/min • Left Ventricular Ejection Fraction (LVEF) < 45% • Active systemic viral, bacterial, or uncontrolled fungal infection. Note: Documentation must show absence of active Hepatitis B, Hepatitis C, and Human Immunodeficiency Virus (HIV) • History of chimeric antigen receptor therapy (CAR-T) or other genetically modified T-cell therapy • An allogenic stem cell transplant within 6 months before apheresis. Note: Participants who received an allogeneic transplant must be off all immunosuppressive medications for 6 weeks without signs of graft-versus-host disease (GVHD) • An autologous stem cell transplant ≤ 12 weeks before apheresis • Presence or history of central nervous system involvement with myeloma	☐	☐	**Please provide documentation**
8. Are the member and requesting provider enrolled in the Carvykti™ Risk Evaluation and Mitigation Strategy (REMS) program?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

****Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-M039
Origination Date: 03/09/2022
Reviewed/Revised Date: 04/19/2023
Next Review Date: 04/19/2024
Current Effective Date: 05/01/2023

HEALTHY U MEDICAID

PRIOR AUTHORIZATION REQUEST FORM
TZIELD®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 801-646-7300.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have medical pharmacy prior authorization questions, please call for assistance: 877-358-8797

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Tzield (teplizumab-mzwv)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Is the request made by an endocrinologist?	☐	☐	
2. Does the member have a diagnosis of Stage 2, Type 1 Diabetes?	☐	☐	**Please provide documentation**
3. Is the member between the ages of 8-45 years old?	☐	☐	
4. Does the member have an abnormal glucose tolerance by OGTT confirmed within 7 weeks of baseline visit defined by one of the following? a. Fasting blood glucose of 110mg/dL to < 126 mg/dL b. 2-hour post-prandial plasma glucose level ≥ 140mg/dL and < 200mg/dL c. Post-prandial glucose level at 30-, 60-, or 90-minutes ≥ 200mg/dL	☐	☐	**Please provide documentation**
5. Does the member have at least two positive pancreatic islet autoantibodies detected in two samples within 6 months of request?	☐	☐	**Please provide documentation**
6. Does the member have a 1st or 2nd degree relative with Type 1 Diabetes?	☐	☐	**Please provide documentation**
7. Has the member been previously treated with Tzield?	☐	☐	

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.
Additional information:
Physician Signature:

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-M044
Origination Date: 05/04/2023
Reviewed/Revised Date: 03/18/2025
Next Review Date: 03/18/2026
Current Effective Date: 04/01/2025

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
NPLATE®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 801-646-7300.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have medical pharmacy prior authorization questions, please call for assistance: 877-358-8797

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Nplate (romiplostim)

Dosing/Frequency: _____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
CHRONIC OR PERSISTENT IMMUNE/ IDIOPATHIC THROMBOCYTOPENIA (ITP)			
1. Does documentation show a diagnosis of chronic or persistent immune/idiopathic thrombocytopenia (ITP)?	☐	☐	**Please provide documentation**
2. Is the request made by a hematologist or oncologist?	☐	☐	
3. Does documentation show the member's platelet count is less than 30,000/mcL?	☐	☐	**Please provide documentation**
4. Has the member had an adequate trial and failure with corticosteroids, unless contraindicated? • Adequate trial defined as prednisone (0.5 - 2.0 mg/kg/day) or dexamethasone (40 mg/day); may be repeated up to 3 times if inadequate response • Failure defined as platelet count not increasing to at least 50,000/mcL or continued requirement for steroids after 3 months of treatment	☐	☐	**Please provide documentation**
HEMATOPOIETIC SYNDROME OF ACUTE RADIATION SYNDROME (HS-ARS)			
1. Does documentation show diagnosis of acute radiation syndrome (HS-ARS) with confirmed or suspected exposure to radiation levels greater than 2 Grays (Gy)?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
CHRONIC OR PERSISTENT IMMUNE/ IDIOPATHIC THROMBOCYTOPENIA (ITP)			
1. Is the request for reauthorization of ITP therapy?	☐	☐	

2. Is there documentation of recent platelet count of 30,000-150,000/mcL?	☐	☐	**Please provide documentation**
3. Does documentation show the medication is providing a clinical benefit for the member?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:

Physician Signature:

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-M045
Origination Date: 05/04/2023
Reviewed/Revised Date: 01/29/2025
Next Review Date: 01/29/2026
Current Effective Date: 02/01/2025

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM

MYASTHENIA GRAVIS

Rystiggo®, Soliris®, Ultomiris®, Vyvgart®, Vyvgart® Hytrulo, Zilbrysq®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 801-646-7300.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for Pharmacy Customer Service for assistance at 877-358-8797

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred/Non-preferred

1. 1st line preferred agents:
   A. Rystiggo® (rozanolixizumab-noli) subcutaneous infusion, Vyvgart® (efgartigimod alfa-fcab) intravenous infusion
2. 2nd line non-preferred agents; after trial and failure of the preferred first-line agents:
   A. Ultomiris® (ravulizumab) intravenous infusion
3. Excluded/Not covered unless failure or contraindication to all other agents:
   A. Soliris® (eculizumab) intravenous infusion; Vyvgart® Hytrulo (efgartigimod alfa/hyaluronidase) subcutaneous infusion, Zilbrysq® (zilucoplan)

Product being requested: _____

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
MYASTHENIA GRAVIS (gMG)			
1. Is the request being made by or in consultation with a neurologist or other specialist in the treatment of gMG?	☐	☐	
2. Does the member have a diagnosis of gMG?	☐	☐	
3. Does the member have a positive serologic test for anti-acetylcholine receptor (anti-AchR) antibodies?	☐	☐	**Please provide documentation**
4. If the request is for Rystiggo®, does the member have a positive serologic test for anti-acetylcholine receptor (anti-AchR) antibodies OR anti-muscle-specific kinase (anti-MuSK) antibodies?	☐	☐	**Please provide documentation**
5. Has the member been diagnosed with class II to IV gMG according to the Myasthenia Gravis Foundation of America?	☐	☐	**Please provide documentation**

6. Has the member tried and failed pyridostigmine AND at least two immunosuppressive therapies (e.g. rituximab, methotrexate, mycophenolate mofetil, azathioprine, cyclosporine) for a total duration of at least 12 months?	☐	☐	**Please provide documentation**
7. Has the member tried and failed intravenous immunoglobulin (IVIG)?	☐	☐	**Please provide documentation**
8. Will the requested therapy be used in combination with IVIG or other biologic agents for gMG treatment?	☐	☐	
9. If the request is for Rystiggo®, is the member's Myasthenia Gravis Activities of Daily Living (MG-ADL) score ≥ 3?	☐	☐	**Please provide documentation**
10. If the request is for Vyvgart®, is the member's MG-ADL score ≥ 5?	☐	☐	**Please provide documentation**
11. If the request is for Soliris® or Ultomiris®, is the member's MG-ADL score ≥ 6?	☐	☐	**Please provide documentation**
12. If the request is for Soliris® or Ultomiris®, is the prescribing physician enrolled in Soliris® or Ultomiris® REMS program?	☐	☐	
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. If the request is for reauthorization of Vyvgart® or Rystiggo®, has the member had a positive clinical response to treatment shown by a ≥ 2 points reduction in MG-ADL score?	☐	☐	**Please provide documentation**
3. If the request is for reauthorization of Soliris® or Ultomiris®, has the member had a positive clinical response to treatment shown by a ≥ 2 points reduction in MG-ADL score or a ≥ 3 points reduction in quantitative myasthenia gravis (QMG) score?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician's Signature:			

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-M046
Origination Date: 08/03/2023
Reviewed/Revised Date: 03/27/2024
Next Review Date: 03/27/2025
Current Effective Date: 04/01/2024

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM

MONOCLONAL ANTIBODIES FOR ALZHEIMER'S DISEASE

Kisunla™, Leqembi®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 801-646-7300.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have medical pharmacy prior authorization questions, please call for assistance: 877-358-8797

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Kisunla™ (donanemab-azbt), ☐ Leqembi® (lecanemab-irmb)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
Is this request for an **expedited** review? By checking the **"Yes"** box to request an expedited review (24 hours), you are certifying that applying the standard review time frame (72 hours) may place the member's life, health, or ability to regain maximum function in serious jeopardy.	☐	☐	
1. Is the prescribing physician a board-certified neurologist or geriatrician that specializes in Alzheimer's Disease (AD) treatment?	☐	☐	**Please provide documentation**
2. Does the member have a diagnosis of AD with mild cognitive impairment or AD with mild dementia AND presence of amyloid abnormalities and/or presence of amyloid beta pathology as determined by PET scan or lumbar puncture within the past 12 months?	☐	☐	**Please provide documentation**
3. Does documentation include an MRI of the brain within the past year without evidence of ANY the following? • Prior cerebral hemorrhage greater than 1 cm in greatest diameter • Greater than 4 microhemorrhages • Superficial siderosis • Vasogenic edema	☐	☐	**Please provide documentation**

• Cerebral contusion, aneurysm, vascular malformation, infective lesions, multiple lacunar infarcts or stroke involving a major vascular territory • Severe small vessel or white matter disease			
4. Has the member had a trial and failure of BOTH cholinesterase inhibitor (e.g., donepezil, rivastigmine) and memantine?	☐	☐	**Please provide documentation**
5. Does the member have contraindication to amyloid testing (e.g. PET or brain MRI)?	☐	☐	**Please provide documentation**
LEQUEMBI			
1. Is the member between the ages of 50 and 90?			
2. Does the member have documentation of all of the following: • Mini-Mental Status Examination (MMSE) score of 22 or greater; and • Clinical Dementia Rating-Global Score of 0.5 or 1; and • Memory Box score of 0.5 or greater; and • Documentation of objective impairment in episodic memory as indicated by at least 1 standard deviation below age-adjusted mean in the Wechsler Memory Scale IV-Logical Memory (subscale) II evaluation?	☐	☐	**Please provide documentation**
KISUNLA			
1. Is the member between the ages of 60 and 85?			
2. Does the member have documentation of a Mini-Mental Status Examination (MMSE) score of 20 or greater?	☐	☐	**Please provide documentation**
LEQEMBI REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member had amyloid-related imaging abnormalities with edema (ARIA-E) or hemosiderin deposition (ARIA-H) before the 5th, 7th, and 14th infusions as determined by brain MRI?	☐	☐	**Please provide documentation**
3. Does the member have continued evidence of mild cognitive impairment as evidenced by an updated CDR global scale score ≤0.5, RBANS delayed memory index score ≤85, and MMSE score ≥24?	☐	☐	**Please provide documentation**
4. Has the member been at least 80% compliant with infusions?	☐	☐	
KISUNLA REAUTHORIZATION			
1. Is the request for reauthorization of therapy?			
2. Has the member had amyloid-related imaging abnormalities with edema (ARIA-E) or hemosiderin deposition (ARIA-H) before the 2nd, 3rd, 4th, and 7th infusions as determined by brain MRI?			**Please provide documentation**
3. Are PET scans completed at 6, 12, and 18 months from initiation of Kisunla provided showing continued necessity as evidenced by NOT meeting Stopping Criteria? Stopping Criteria includes at least ONE of the following: a. Amyloid plaque level <11 centiloids on a <u>single</u> PET scan, or b. Amyloid plaque level 11 to <25 centiloids on <u>2 consecutive</u> PET scans			**Please provide documentation**
4. Does the member have continued evidence of mild cognitive impairment as evidenced by an updated MMSE score ≥24?			**Please provide documentation**

5. Has the member been at least 80% compliant with infusions?			
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HCU-M047
Origination Date: 8/9/2023
Reviewed/Revised Date: 09/18/2024
Next Review Date: 09/18/2025
Current Effective Date: 10/01/2024

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
PAROXYSMAL NOCTURNAL HEMOGLOBINURIA
Soliris®, Ultomiris®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department at 801-646-7300.

Failure to submit clinical documentation to support this request will result in dismissal of the request.

If you have prior authorization questions, please call for assistance: 877-358-8797

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred/Non-Preferred/Non-Formulary

1. Preferred
   A. Ultomiris® (ravulizumab)
2. Non-Preferred
   A. Soliris® (eculizumab)
3. Non-Formulary
   A. Empaveli® (pegcetacoplan), Fabhalta® (iptacopan), PiaSky® (crovalimab-akkz), Voydeya™ (danicopan)

Product being requested: _____

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Is the requesting provider a hematologist or oncologist, or in consultation with one?	☐	☐	
2. Is the diagnosis of Paroxysmal Nocturnal Hemoglobinuria (PNH) confirmed by flow cytometry?	☐	☐	**Please provide documentation**
3. Is the member transfusion dependent requiring at least four transfusions in the past 12 months?	☐	☐	**Please provide documentation**
4. Does the member have a history of a major thrombotic event?	☐	☐	**Please provide documentation**
5. Does the member have high lactate dehydrogenase (LDH) activity with serum levels ≥1.5 times the upper limit of normal and have clinical symptoms?	☐	☐	**Please provide documentation**
6. Does documentation include baseline values of serum lactate dehydrogenase (LDH), hemoglobin level, and frequency of packed red blood cell transfusions?	☐	☐	**Please provide documentation**

7. Has the member had Neisseria meningitis vaccination at least 2 weeks prior to start date?	☐	☐	
8. Is the prescribing physician enrolled in the Risk Evaluation and Mitigation Strategies (REMS) program for the requested agent?	☐	☐	
9. If the request for Soliris®, has the member tried and failed Ultomiris®, unless contraindicated?	☐	☐	**Please provide documentation**
10. Will the requested therapy be used in combination with another complement inhibitor to treat PNH?	☐	☐	
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member had a decrease in serum LDH from baseline?	☐	☐	**Please provide documentation**
3. Has the member had an improvement in hemoglobin level from baseline?	☐	☐	**Please provide documentation**
4. Has the member had a decrease in packed red blood cell transfusion frequency from baseline?	☐	☐	**Please provide documentation**
5. Has the member maintained meningitis vaccination in accordance to current recommendations for treatment?	☐	☐	
6. Is the member receiving a complement inhibitor in combination with another complement inhibitor?	☐	☐	
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

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