

# 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
<b>Acne Vulgaris</b>			
1. Does the member have a diagnosis of acne vulgaris?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Does documentation show that the member has tried and failed ALL of the following categories: <ul style="list-style-type: none"> <li>• topical benzoyl peroxide</li> <li>• topical or oral antibiotic (e.g. clindamycin, sulfacetamide, erythromycin)</li> <li>• topical retinoid (e.g. adapalene, tretinoin, tazarotene)</li> <li>• Topical generic dapsone or tazarotene</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>Rosacea</b>			
1. Does the member have a diagnosis of rosacea?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Does documentation show that the member has failed a trial of a topical metronidazole agent, a topical generic azelaic acid and ivermectin cream?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>REAUTHORIZATION</b>			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member's therapy been re-evaluated within the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	

3. Does the member show a continued medical need for the therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
Additional information:			
Physician's Signature:			

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Policy: PHARM-HCU-001  
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 Reviewed/Revised Date: 05/22/2024  
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# HEALTH | CHOICE

UTAH

## PRIOR AUTHORIZATION REQUEST FORM

### ALPHA- 1 PROTEINASE INHIBITORS

Aralast NP<sup>®</sup>, Glassia<sup>®</sup>, Prolastin-C<sup>®</sup>, Zemaira<sup>®</sup>

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Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
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**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<sup>®</sup> (alpha<sub>1</sub>-proteinase inhibitor (human)),  Glassia<sup>®</sup> (alpha<sub>1</sub>-proteinase inhibitor (human))  
 Prolastin-C<sup>®</sup> (alpha<sub>1</sub>-proteinase inhibitor (human)),  Zemaira<sup>®</sup> (alpha<sub>1</sub>-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?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the member 18 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Does the member have a confirmed phenotype of PiZZ, piZ(null), or Pi(null)(null)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Is the request made by, or in consultation with, a pulmonologist?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Does the member have clinically evident emphysema due to AAT deficiency?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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?	<input type="checkbox"/>	<input type="checkbox"/>	
7. Does the member have a pretreatment serum concentration of AAT < 11µM/L (< 80mg/dL by radial immunodiffusion or 50mg/dL by nephelometry ?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
8. Is the member an active tobacco smoker?	<input type="checkbox"/>	<input type="checkbox"/>	

### REAUTHORIZATION

1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
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2. Does documentation show that the member has responded to treatment, such as elevated AAT levels above baseline and/or substantial reduction in lung function deterioration as demonstrated by FEV1 values?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
Additional information:			
Physician's Signature:			

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Policy PHARM-HCU-002  
 Origination Date: 01/01/2022  
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# HEALTH CHOICE

UTAH

## PRIOR AUTHORIZATION REQUEST FORM

### ANKYLOSING SPONDYLITIS

Avsola®, Cimzia®, Cosentyx®, Enbrel®, Hadlima™, Humira®, Inflectra®, infliximab,  
Remicade®, Renflexis®, Rinvoq®, 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

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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-bwvd)
  - 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 and a preferred infliximab agent:**
  - A. Cimzia® (certolizumab), Humira® (adalimumab), Taltz® (ixekizumab), Xeljanz/XR® (tofacitinib)
- 3. Non-Formulary agents with a triple step; after trial and failure of BOTH Hadlima and a preferred infliximab agent and 2 second line agents:**
  - A. Cosentyx® (secukinumab), Enbrel® (etanercept), 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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Is the requesting provider a rheumatologist or in consultation with one?	<input type="checkbox"/>	<input type="checkbox"/>	
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

4. Has the provider performed tuberculosis (TB) screening prior to therapy initiation?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. If the request is for a tumor necrosis factor inhibitor, has the provider performed hepatitis B screening prior to therapy initiation?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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, Humira and/or Simponi?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>REAUTHORIZATION</b>			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does updated documentation show that the member has a continued medical need?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Has the provider performed continued tuberculosis screening during therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Has the provider performed continued Hepatitis B monitoring in HBV carriers?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
Additional information:			
Physician's Signature:			

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Policy: PHARM-HCU-003  
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# HEALTH | CHOICE

UTAH

## PRIOR AUTHORIZATION REQUEST FORM

### ANTHELMINTICS

albendazole, Alinia®, Emverm®, nitazoxanide

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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
<b>ALBENDAZOLE</b>			
1. Is the medication request for a quantity of #4 per 30 days for treatment of pinworms/roundworm?	<input type="checkbox"/>	<input type="checkbox"/>	<b>No prior authorization required</b>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>EMVERM®</b>			
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. If the request is to treat pinworm (enterobiasis), does documentation show a trial and failure of over-the-counter pyrantel pamoate, unless contraindicated?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>NITAZOXANIDE</b>			
1. Does the member have a diagnosis of Cryptosporidiosis?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

2. If the member has a diagnosis of giardiasis, does documentation show a trial and failure of metronidazole, unless contraindicated?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
Additional information:			
Physician's Signature:			

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Policy PHARM-HCU-004  
 Origination Date: 01/01/2022  
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 Next Review Date: 03/27/2025  
 Current Effective Date: 04/01/2024

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# HEALTH | CHOICE

UTAH

## PRIOR AUTHORIZATION REQUEST FORM

### Brand Antiemetics for Chemotherapy Induced Nausea and Vomiting

Akynzeo® (netupitant and palonosetron) Capsules,  
 Sancuso® (granisetron) patch, Sustol® (granisetron) subcutaneous injection, Varubi® (rolapitant) tablets,  
 Zuplenz® (ondansetron) film

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

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**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
<b>AKYNZEO®</b>			
1. Is this request for prevention of nausea and vomiting associated with moderately to highly emetogenic intravenous chemotherapy regimens?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member tried and failed aprepitant or fosaprepitant in combination with palonosetron?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>SANCUSO®</b>			
1. Is this request for prevention of nausea and vomiting associated with moderately to highly emetogenic intravenous chemotherapy regimens?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member tried and failed all of the following: <ul style="list-style-type: none"> <li>• ondansetron</li> <li>• granisetron</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>SUSTOL®</b>			
1. Is this request for prevention of nausea and vomiting associated with moderately to highly emetogenic intravenous chemotherapy regimens?	<input type="checkbox"/>	<input type="checkbox"/>	

2. Has the member tried and failed all of the following: <ul style="list-style-type: none"> <li>• Ondansetron</li> <li>• Granisetron</li> <li>• Sancuso® patch</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>VARUBI®</b>			
1. Is this request for prevention of nausea and vomiting associated with moderately to highly emetogenic intravenous chemotherapy regimens?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member tried and failed aprepitant and fosaprepitant?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>ZUPLENZ®</b>			
1. Is this request for prevention of nausea and vomiting associated with moderately to highly emetogenic intravenous chemotherapy regimens?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member tried and failed all of the following: <ul style="list-style-type: none"> <li>• Ondansetron ODT</li> <li>• Granisetron</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
Additional information:			
Physician Signature:			

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Policy PHARM-HCU- 006  
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# HEALTH CHOICE

UTAH

## PRIOR AUTHORIZATION REQUEST FORM

### ARANESP®

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**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?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does documentation show that the member's hemoglobin is <10 g/dL and/or that the hematocrit is <30%?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Does the member have one of the following indications: <ul style="list-style-type: none"> <li>• Anemia of chronic renal failure,</li> <li>• Anemia due to myelosuppressive chemotherapy with a minimum of 8 additional weeks of planned chemotherapy,</li> <li>• Myelodysplasia or myelodysplastic syndrome?</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Does the member have one of the following indications: <ul style="list-style-type: none"> <li>• Request will be used as a substitute for red blood cell transfusion in patients who require immediate correction of anemia,</li> <li>• Uncontrolled hypertension,</li> <li>• Pure Red Cell Aplasia (PRCA) that begins after treatment with erythropoietin drugs?</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	

#### REAUTHORIZATION

1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
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2. Has the member responded to treatment, demonstrated by an improvement in the hematocrit and hemoglobin levels or a significant decrease in transfusion requirements?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Is current hemoglobin < 11g/dL OR > 10 to <12 g/dL?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
Additional information:			
Physician's Signature:			

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Policy: PHARM-HCU-008  
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# HEALTH CHOICE

UTAH

## PRIOR AUTHORIZATION REQUEST FORM

### BASAL INSULIN

Insulin Glargine, Toujeo®, Insulin Degludec

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***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
<b>Insulin Degludec</b>			
1. Does the member have a diagnosis of Type 1 or Type 2 diabetes mellitus or gestational diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Has the member trialed Basaglar® or Rezvoglar® for at least 3 months?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>Toujeo and Insulin Glargine</b>			
1. Does the member have a diagnosis of Type 1 or Type 2 diabetes mellitus or gestational diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

2. Has the member trialed Basaglar® or Rezvoglar® and Insulin Degludec for at least 3 months?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>REAUTHORIZATION</b>			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member's therapy been re-evaluated within the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Does the member show a continued medical need for the therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Has the therapy been tolerable and effective?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
Additional information:			
Physician Signature:			

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Policy: PHARM-HCU-011  
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 Current Effective Date: 01/01/2024

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# HEALTH | CHOICE

UTAH

## PRIOR AUTHORIZATION REQUEST FORM

### CYSTIC FIBROSIS TRANSMEMBRANE CONDUCTANCE REGULATOR (CFTR) AGENTS

Kalydeco<sup>®</sup>, Orkambi<sup>®</sup>, Symdeko<sup>®</sup>, Trikafta<sup>™</sup>

**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<sup>®</sup> (ivacaftor),  Orkambi<sup>®</sup> (lumacaftor/ivacaftor),  Symdeko<sup>®</sup> (tezacaftor/ivacaftor and ivacaftor),  Trikafta<sup>™</sup> (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? <ul style="list-style-type: none"> <li>• Cystic fibrosis with pulmonary manifestations</li> <li>• Cystic fibrosis with other intestinal manifestations</li> <li>• Cystic fibrosis with other manifestations</li> <li>• Cystic fibrosis, unspecified</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Is the requesting provider a cystic fibrosis specialist?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Does the provided documentation show that the member has a CF mutation that the requested medication is indicated to treat?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Does the member have a baseline forced expiratory volume in one second (FEV1) between 40% and 90% of predicted normal value?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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.	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Does the member demonstrate at least 80% adherence to prescribed medication therapies over the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

Adherence to prescribed medications will be verified by claim review and fill history, if available.			
<b>REAUTHORIZATION</b>			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does the member have a continued medical need for therapy and has the therapy been effective and tolerable?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Has member achieved a clinically significant response to therapy with documentation of at least ONE of the following? <ul style="list-style-type: none"> <li>• Improvement or stabilization in lung function as demonstrated by a current FEV1 as compared to pre-treatment values.</li> <li>• Improvement or stabilization in Body Mass Index (BMI) as compared to pre-treatment BMI.</li> <li>• Member has a decrease in pulmonary exacerbations as demonstrated by a decrease in hospitalizations, emergency room visits and/or IV antibiotic use.</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Is the member followed at least annually by a practitioner who specializes in the care of patients with cystic fibrosis?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>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.</b>			
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: 03/16/2023  
Next Review Date: 03/16/2014  
Current Effective Date: 04/01/2023

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# HEALTH CHOICE

UTAH

## PRIOR AUTHORIZATION REQUEST FORM

### CLOSTRIDIUM DIFFICILE DRUGS

Dificid<sup>®</sup>, Zinplava<sup>™</sup>

**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:		
<p><b><i>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.</i></b></p>		
<p><b>Product being requested:</b> <input type="checkbox"/> Dificid<sup>®</sup> (fidaxomicin), <input type="checkbox"/> Zinplava<sup>™</sup> (bezlotuxumab)</p>		
<p>Dosing/Frequency: _____</p>		

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

6. Is the member at high risk of C. difficile recurrence by meeting one of the following: <ul style="list-style-type: none"> <li>• Age ≥ 65 years</li> <li>• History of C. difficile infection in the past 6 months</li> <li>• Immunocompromised state</li> <li>• C. diff ribotype 027</li> <li>• Severe C. difficile infection at presentation with white blood cell ≥15,000 cells/mm<sup>3</sup> OR serum creatinine &gt; 1.5g/dL</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>REAUTHORIZATION</b>			
1. Is the request for reauthorization of Difucid®?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does updated documentation show continued medical need and tolerance of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
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: 03/16/2023  
 Next Review Date: 03/16/2024  
 Current Effective Date: 04/01/2023

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# 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
<b>EPISODIC MIGRAINE, CHRONIC MIGRAINE</b>			
1. Does the member have a diagnosis of episodic or chronic migraines?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Has the member had at least a <b>3-month trial and failure of a beta-blocker</b> (propranolol, metoprolol, etc.) and <b>at least 1</b> of the following: <ul style="list-style-type: none"> <li>• Calcium channel blocker (verapamil, nifedipine, etc.)</li> <li>• Antidepressant (amitriptyline, venlafaxine, etc.)</li> <li>• Anticonvulsant (topiramate, gabapentin, divalproex, etc.)</li> <li>• Angiotensin converting enzyme (ACE) inhibitor (Lisinopril, etc.), OR</li> </ul> <b>If a beta-blocker cannot be tried, does documentation show a trial and failure of at least 2 of the agents listed above?</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Is the member taking a Calcitonin Gene-Related Peptide (CGRP) medication or Reyvow (lasmiditan) to treat migraine headaches?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

<ul style="list-style-type: none"> <li>• Ajoovy®(Fremanezumab-vfrm)</li> <li>• Emgality®(galcanezumab-gnlm)</li> </ul>			
<p>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?</p> <ul style="list-style-type: none"> <li>• Ajoovy®(Fremanezumab-vfrm)</li> <li>• Emgality®(galcanezumab-gnlm)</li> <li>• Aimvog®(erenumab-aooe)</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<p>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?</p> <ul style="list-style-type: none"> <li>• Ajoovy®(Fremanezumab-vfrm)</li> <li>• Emgality®(galcanezumab-gnlm)</li> <li>• Aimvog®(erenumab-aooe)</li> <li>• Qulipta®(atogepant)</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>CLUSTER HEADACHE</b>			
<p>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?</p>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<p>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?</p>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>REAUTHORIZATION</b>			
<p>1. Is the request for reauthorization of therapy?</p>	<input type="checkbox"/>	<input type="checkbox"/>	
<p>2. Does documentation show the member had a positive response to therapy?</p>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<p><b>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.</b></p>			
<p>Additional information:</p>			

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: 03/27/2024  
Next Review Date: 03/27/2025  
Current Effective Date: 04/01/2024

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# 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),  Movantik® (naloxegol)

**Non-preferred:**  Amitiza® (lubiprostone),  Motegrity™ (prucalopride),  Relistor® (methylnaltrexone),  
 Symproic® (naldemedine),  Trulance® (plecanatide)

Dosing/Frequency: \_\_\_\_\_

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

Questions	Yes	No	Comments/Notes
<b>CHRONIC IDIOPATHIC CONSTIPATION</b>			
1. Is the request for Linzess®?	<input type="checkbox"/>	<input type="checkbox"/>	
2. If the request is for Amitiza®, Motegrity® or Trulance®, has the member had an adequate trial and failure of Linzess®?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Has the member been diagnosed with Chronic Idiopathic Constipation?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Has the member had a trial and failure of a laxative such as lactulose or polyethylene glycol?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>IRRITABLE BOWEL SYNDROME WITH CONSTIPATION</b>			
1. Is the request for Linzess®?	<input type="checkbox"/>	<input type="checkbox"/>	
2. If the request is for Amitiza® or Trulance®, has the member had an adequate trial and failure with Linzess®?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Has the member been diagnosed with Irritable Bowel Syndrome with constipation?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Has the member had a trial and failure of a laxative such as lactulose or polyethylene glycol?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. If the request is for Amitiza, is the member female?	<input type="checkbox"/>	<input type="checkbox"/>	

OPIOID INDUCED CONSTIPATION			
1. Is the request for Movantik®?	<input type="checkbox"/>	<input type="checkbox"/>	
2. If the request is for Amitiza® or Symproic®, has the member had an adequate trial and failure of Movantik®?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Has the member been diagnosed with opioid induced constipation?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Has the member had a trial and failure of a laxative such as lactulose or polyethylene glycol?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member's therapy been re-evaluated within the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Has the therapy shown to be effective with an improvement in the member's condition?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Does the member show a continued medical need for the therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
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: 03/27/2024  
 Next Review Date: 03/27/2025  
 Current Effective Date: 04/01/2024

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# HEALTH | CHOICE

UTAH

## PRIOR AUTHORIZATION REQUEST FORM CROHN'S DISEASE MEDICATIONS

Avsola®, Cimzia®, Entyvio®, Hadlima™, Humira®, Inflectra®, infliximab,  
Remicade®, Renflexis®, Rinvoq®, Skyrizi®, Stelara®

**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. Hadlima™ (adalimumab-bwwd)
- 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 and a preferred infliximab agent:**

- A. Cimzia® (certolizumab), Entyvio® (vedolizumab) IV, Humira® (adalimumab)

**3. Non-Formulary agents with a triple step; after trial and failure of BOTH Hadlima and a preferred infliximab agent and Entyvio:**

- A. Rinvoq® (upadacitinib), Skyrizi® (risankizumab-rzaa), Stelara® (ustekinumab)

**4. Non-Formulary Agent after trial and failure of all the above:**

- A. Entyvio® (vedolizumab) subcutaneous injection

**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?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does documentation include results from studies such as colonoscopy, MRI, CT scan?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

3. Does the member have severe Crohn's Disease evidenced by at least one of the following: <ul style="list-style-type: none"> <li>• A Crohn's Disease Activity Score (CDAI) &gt;220 AND as shown on imaging</li> <li>• Active fistulizing disease</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Does the member have moderate to severe Crohn's Disease evidenced by the following: <ul style="list-style-type: none"> <li>• Persistent fistulizing disease or active ulcerative disease as shown on imaging and via CDAI &gt; 150 despite an adequate trial with an immunomodulating medication such as methotrexate, azathioprine or 6-mercaptopurine, unless contraindicated to all.</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Has the provider performed tuberculosis (TB) screening prior to therapy initiation?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. If the request is for a Tumor Necrosis Factor Inhibitor, has the provider performed hepatitis B screening prior to therapy initiation?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>REAUTHORIZATION</b>			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Has the provider performed continued tuberculosis monitoring during therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Has the provider performed continued Hepatitis B monitoring in HBV carriers?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
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: 05/22/2024  
Next Review Date: 05/22/2025  
Current Effective Date: 06/01/2024

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# 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
<b>ASTHMA</b>			
1. Does the member have a diagnosis of moderate to severe asthma?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Is the request made by, or in consultation with, an allergist, pulmonologist or immunologist?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Has the member had a trial and failure of Fasentra® (benralizumab), unless contraindicated?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Does the member have poor asthma control with recurrent exacerbations that have required emergency department visits, hospitalizations, or frequent office visits?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Does documentation show that the member's FEV1 is less than 80%?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
7. Are underlying conditions or triggers for asthma or pulmonary disease being maximally managed (i.e. inhaled respiratory irritants – tobacco, allergen exposure, physical activity,	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

medications, emotional factors, respiratory infections, COPD, etc.)?			
8. Does the member have a baseline eosinophil count $\geq 300$ cells/ $\mu\text{L}$ in the last 6 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
9. Has the member required daily oral corticosteroid therapy for at least the last 6 months?			
<b>EOSINOPHILIC ESOPHAGITIS (EoE)</b>			
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Is the request made by, or in consultation with, an allergist, or a gastroenterologist?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Has the member had a trial and failure of the following: <ul style="list-style-type: none"> <li>• Diet modification</li> <li>• Proton-Pump Inhibitor</li> <li>• Topical glucocorticosteroid treatment</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Does the member weigh more than 40kg?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>PRURIGO NODULARIS (PN)</b>			
1. Is the request made by a provider specializing in dermatology, allergy, or immunology?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the disease involvement rated as moderate to severe?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Has the member tried phototherapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Has the member had an adequate trial with at least two moderate to very high potency prescription corticosteroids?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Has the member tried cyclosporine or methotrexate within the past 6 months?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>REAUTHORIZATION</b>			
<b>ASTHMA</b>			
1. Is the request for reauthorization for asthma therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is there evidence of positive clinical response as defined by documentation demonstrating reduced hospitalization and/or emergency room visits?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>EOSINOPHILIC ESOPHAGITIS (EoE)</b>			
1. Is the request for reauthorization of chronic EoE therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is there evidence of positive clinical response as defined by documentation demonstrating improvement in eos/hpf from baseline and symptoms?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>PRURIGO NODULARIS (PN)</b>			
1. Is the request for reauthorization of prurigo nodularis therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is there evidence of a positive clinical response to therapy?			<b>Please provide documentation</b>
<b>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.</b>			

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: 03/27/2024  
Next Review Date: 03/27/2025  
Current Effective Date: 04/01/2024

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# 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
<b>ADVANCED BREAST CANCER</b>			
1. Does the member have a diagnosis of advanced breast cancer?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Is the member ≥18 years of age?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Is the prescriber an oncologist or endocrinologist?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Is the request for the preferred product Zoladex®?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>CENTRAL PRECOCIOUS PUBERTY</b>			
1. Does the member have a diagnosis of central precocious puberty?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the prescriber a pediatric endocrinologist?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Does documentation show baseline LH levels and a LH concentration after GnRH stimulation test?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Does documentation show a baseline LH/FSH ratio and a LH/FSH ratio after GnRH stimulation test ?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

5. Does documentation show the member's baseline bone age is 1 year greater than chronological age?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Does documentation include the member's age at onset of secondary sexual characteristics?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
7. Does documentation show the member's Tanner Stage is $\geq$ 2?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
8. Have the following diagnoses been ruled out? <ul style="list-style-type: none"> <li>• Adrenal steroid levels for congenital adrenal hyperplasia</li> <li>• Beta human chorionic gonadotropin level for chorionic gonadotropin secreting tumor</li> <li>• Pelvic/adrenal/testicular ultrasound for steroid secreting tumor</li> <li>• CT scan of head to rule out intracranial tumor</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
9. Is the request for the preferred product Lupron Depot-Ped® or Vantas®?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>ENDOMETRIOSIS</b>			
1. For endometriosis with inadequate pain control, is the request for the preferred product Lupron Depot® or Zoladex®? <b>Imaging confirming the diagnosis is required.</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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. <b>Imaging confirming the diagnosis is required.</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. For endometriosis with dyspareunia and inadequate pain control, is the request for Orilissa® 200 mg? 5. <b>Imaging confirming the diagnosis is required.</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Is the requesting provider an OB/GYN?	<input type="checkbox"/>	<input type="checkbox"/>	
7. Does documentation show a negative pregnancy test?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
8. Has the member tried and failed at least two of the following: <ul style="list-style-type: none"> <li>• A combination (estrogen-progesterone) contraceptive taken continuously</li> <li>• A progestin such as DepoProvera® (medroxyprogesterone), Nexplanon® (etonogestrel) or Mirena® (levonorgestrel)</li> <li>• Danazol</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>ENDOMETRIAL THINNING</b>			
1. Is the member $\geq$ 18 years of age?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the requesting provider an OB/GYN?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Is the requested therapy for dysfunctional uterine bleeding prior to endometrial ablation?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Is the request for the preferred product Zoladex®?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>PROSTATE CANCER</b>			
1. Is the member $\geq$ 18 years of age?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the requesting prescriber an oncologist or endocrinologist?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Is the request for the preferred product Eligard®?	<input type="checkbox"/>	<input type="checkbox"/>	

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<b>UTERINE LEIOMYOMATA</b>			
1. Is the request for the preferred product Lupron Depot®?	<input type="checkbox"/>	<input type="checkbox"/>	<b>If yes, please complete questions 2 to 4</b>
2. Is the member ≥ 18 years of age?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Does the member have a diagnosis of uterine leiomyomata requiring option of surgical intervention?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Does documentation show a clinical estimation of the size of uterus or fibroids?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Is the request for Oriahnn®?	<input type="checkbox"/>	<input type="checkbox"/>	<b>If yes, complete questions 6 to 11</b>
6. Is the prescribing provider an OB/GYN, or in consultation with one?	<input type="checkbox"/>	<input type="checkbox"/>	
7. Has the member tried and failed Lupron Depot® AND at least one of the following therapies unless contraindicated? <ul style="list-style-type: none"> <li>• Combined estrogen-progestin contraceptive</li> <li>• Levonorgestrel-releasing intrauterine systems</li> <li>• Tranexamic acid</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
8. Does the member have a clinical diagnosis of uterine leiomyomata (fibroid) as shown by ultrasound?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
9. Does the member have a negative pregnancy test?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
10. Has an endometrial biopsy been performed to rule out endometrial cancer?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
11. Does the member have a t-score > -2.0 at the lumbar spine, total hip, and femoral neck?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>ADOLESCENT GENDER DYSPHORIA</b>			
1. See PHARM-HCU-150 Hormone Therapy for Gender Dysphoria.	<input type="checkbox"/>	<input type="checkbox"/>	
<b>REAUTHORIZATION</b>			
<b>Breast Cancer</b>			
1. Does the member have a continued medical need for therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Has the therapy been effective and tolerable?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>CENTRAL PRECOCIOUS PUBERTY</b>			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does documentation show suppression of increasing LH and FSH levels from baseline?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Has the member's height velocity slowed or stabilized from baseline?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Has the member's bone age slowed from baseline?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Is there a stabilization or regression of the member's Tanner Staging?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Is the member ≤12 years of age if female or ≤13 years of age if male?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>ENDOMETRIOSIS</b>			
1. Does the member have a recurrence of symptoms?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Is the request for Lupron Depot® (leuprolide) or Zoladex® (goserelin) AND has the member received < 12 months of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

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PROSTATE CANCER			
1. Does the member have a continued medical need for therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Has the therapy been effective and tolerable?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
UTERINE LEIOMYOMATA			
1. Does the member have a continued medical need for therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Is the request for Oriahnn® AND has the member received < 24 months of therapy months of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
ADOLESCENT GENDER DYSPHORIA			
1. See PHARM-HCU-150 Hormone Therapy for Gender Dysphoria for reauthorization.	<input type="checkbox"/>	<input type="checkbox"/>	
<b>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.</b>			
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: 07/31/2023  
 Next Review Date: 07/31/2024  
 Current Effective Date: 08/01/2023

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# 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),  Nutropin AQ® (somatropin)

**Non-Formulary:**  Genotropin® (somatropin),  Humatrope® (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
<b>GROWTH HORMONE DEFICIENCY IN ADULTS</b>			
1. Does the member have the diagnosis of growth hormone deficiency in adults?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the ordering provider an endocrinologist?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Does the member have a pituitary hormone deficiency (other than growth hormone) requiring hormone replacement therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Has the member had a growth hormone provocative stimulation test with a measured peak level of <5 ng/mL?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

SHORT BOWEL SYNDROME			
1. Does the member have the diagnosis of Short Bowel Syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the provider a gastroenterologist?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Is the member able to ingest solid food?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Is the member receiving parenteral nutrition at least 5 days/week to provide at least 3,000 calories per week?	<input type="checkbox"/>	<input type="checkbox"/>	
5. Has the member met with a nutritionist and documentation indicates that dietary needs and goals have been discussed?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)			
1. Does the member have the diagnosis of Acquired Immune Deficiency Syndrome (AIDS) Wasting Syndrome in adults?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the requesting provider an infectious disease specialist?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Is the member currently take antiretroviral medications?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Does the member have a documented weight loss of at least 10% from baseline weight OR a body mass index (BMI) of <20?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Has the member had an adequate nutritional evaluation and has failed to respond to a high calorie intake diet?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does updated documentation show continued medical necessity and clinical efficacy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. For a diagnosis of AIDS, has the member demonstrated weight gain within the initial 12 weeks of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
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  
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 Next Review Date: 01/17/2025  
 Current Effective Date: 02/01/2024

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# 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),  Nutropin AQ® (somatropin)

**Non-Formulary:**  Genotropin® (somatropin),  Humatrope® (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
<b>GROWTH HORMONE DEFICIENCY (GHD)</b>			
1. Does the member have the diagnosis of GHD in children?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the requesting provider a pediatric endocrinologist?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Has the member had TWO separate growth hormone stimulation tests with levels less than 10ng/mL? <ul style="list-style-type: none"> <li>• 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.</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Does the member have two or more other pituitary hormone deficiencies in addition to GHD?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

<ul style="list-style-type: none"> <li>GH stimulation tests, IGF-1 or IGF-BP3 levels are not needed if multiple pituitary hormone deficiencies exist.</li> </ul>			
6. Does the member have congenital GHD? <ul style="list-style-type: none"> <li>GH stimulation tests, IGF-1 or IGF-BP3 levels are not needed for GHD if multiple pituitary hormone deficiencies exist.</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
7. Does the member have documentation of short stature/growth failure?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
8. Is the member height below the 3 <sup>rd</sup> percentile for the member's age and gender?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
9. Does the member have an untreated growth velocity below the 25 <sup>th</sup> percentile AND a height below the 5 <sup>th</sup> percentile for the members age and gender?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
10. Does the member have open growth plates?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide initial bone age</b>
<b>PRADER-WILLI SYNDROME (PWS)</b>			
1. Does the member have the diagnosis of PWS?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the requesting provider a pediatric endocrinologist?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Has the diagnosis of PWS been confirmed with genetic testing?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Is the member severely obese, have a history of upper airway obstruction or sleep apnea, or have a severe respiratory impairment?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>SMALL GESTATIONAL AGE</b>			
1. Is the request for growth failure in children who fail to demonstrate catch-up growth by age 2 to 4 years?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the requesting provider a pediatric endocrinologist?	<input type="checkbox"/>	<input type="checkbox"/>	
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Have other causes for short stature such as growth inhibiting medication, endocrine disorders, and emotional deprivation or syndromes been ruled out?	<input type="checkbox"/>	<input type="checkbox"/>	
6. Does the member have open growth plates?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide initial bone age</b>
7. Is the member 2 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>TURNER'S OR NOONAN'S SYNDROME</b>			
1. Is the request for growth failure associated with Turner's or Noonan's Syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the requesting provider a pediatric endocrinologist?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Does the member have open growth plates?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide initial bone age</b>
4. Does documentation show subnormal growth rate when height is below the 10 <sup>th</sup> percentile for the member's age and gender?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>SHORT STATURE HOMEBOX-CONTAINING GENE (SHOX) DEFICIENCY</b>			
1. Is the request for short stature or growth failure in children with short stature homeobox-containing gene (SHOX) deficiency?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the requesting provider a pediatric endocrinologist?	<input type="checkbox"/>	<input type="checkbox"/>	

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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Does the member have open growth plates?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide initial bone age</b>
<b>CHRONIC RENAL INSUFFICIENCY</b>			
1. Is the request for growth failure associated with chronic renal insufficiency?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the requesting provider a pediatric nephrologist?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Does documentation show subnormal growth rate when height is below the 5 <sup>th</sup> percentile and untreated growth velocity with a minimum of 1 year of growth data is below the 25 <sup>th</sup> percentile for member's age and gender?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Does the member require weekly dialysis or have a glomerular filtration rate (GFR) <75 ml/min/1.73 m <sup>2</sup> ?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Does the member have open growth plates?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide initial bone age</b>
<b>PEDIATRIC BURNS</b>			
1. Is the request for a pediatric member with burns ≥ 40% of the total body surface area?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Is the requesting provider a trauma/burn surgeon?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>NON-GROWTH HORMONE DEFICIENT SHORT STATURE (IDIOPATHIC SHORT STATURE)</b>			
1. Is the pediatric member 5 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>	
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Are the epiphyses open?	<input type="checkbox"/>	<input type="checkbox"/>	
6. Does the member have constitutional delay of growth and puberty (CDGP)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>REAUTHORIZATION</b>			
1. Is the request for reauthorization of therapy? <b>Note: For pediatric burns a maximum of 12 months of therapy may be allowed.</b>	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member's growth velocity been ≥2.5 cm/year?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Is the member's bone age ≤16 in males or ≤14 in females?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. For chronic renal insufficiency, does the member require weekly dialysis or have a glomerular filtration rate (GFR) <75 mL/min/1.73 m <sup>2</sup> ?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			

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: 01/17/2024

Next Review Date: 01/17/2025

Current Effective Date: 02/01/2024

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# HEALTH CHOICE

UTAH

## 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
<b>For use in Hepatitis C Virus (HCV) infection</b>			
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)?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does the member have a documented diagnosis of chronic HCV infection with documentation of a positive qualitative HCV RNA test?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Does documentation include a quantitative viral load?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Has the member's HCV genotype been obtained? • Not required for Sofosbuvir/velpatasvir (Epclusa® authorized generic)	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Does the member have current issues with compliance?	<input type="checkbox"/>	<input type="checkbox"/>	
6. If the member has a psychiatric condition, is the member currently stable and adequately managed?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
7. If the request is for Mavyret, does the member have moderate or severe impairment (Child-Pugh class B or C)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

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)?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does the member have a documented diagnosis of chronic HCV infection with documentation of a positive qualitative HCV RNA test?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Does documentation include a quantitative viral load?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. If the member had a sofosbuvir-based treatment failures, is the request for the preferred agent Mavyret?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. If the member had a Mavyret treatment failure, is the request for Vosevi?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
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  
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# HEALTH CHOICE

UTAH

## 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)?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the requesting provider a board-certified immunologist or allergist?	<input type="checkbox"/>	<input type="checkbox"/>	
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Has the member's diagnosis of Hereditary Angioedema been confirmed with complement 4 (C4) protein and C1-inhibitor levels?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Has the member had a trial and failure of each of the following: antihistamines, glucocorticoids, and epinephrine?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Is the member currently taking ACE-inhibitors or estrogen-containing oral medications?	<input type="checkbox"/>	<input type="checkbox"/>	
7. Has the member's attack frequency, severity, and location been documented?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

8. Is the member/caregiver able and ready to administer medication at home?	<input type="checkbox"/>	<input type="checkbox"/>	
9. For acute HAE attack treatment: Does the member have a history of at least one attack per year?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
11. For long-term prophylaxis of HAE attacks: Has the member tried and failed, or have a contraindication to, danazol therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>REAUTHORIZATION</b>			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member experienced unacceptable toxicity (e.g. hypersensitivity reactions, serious thrombotic events, significantly elevated hepatic serum transaminases) to the drug?	<input type="checkbox"/>	<input type="checkbox"/>	
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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?	<input type="checkbox"/>	<input type="checkbox"/>	
5. For long-term prophylaxis of HAE attacks: Has the member had significant improvements in severity and duration of attacks compared to baseline?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
Additional information:			
Physician's Signature:			

**\*\*Failure to submit clinical documentation to support this request will result in delay and/or denial of the request\*\***

Policy PHARM-HCU-031  
 Origination Date: 01/01/2022  
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 Next Review Date: 01/27/2023  
 Current Effective Date: 02/01/2022

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# HEALTH CHOICE

UTAH

## PRIOR AUTHORIZATION REQUEST FORM

### HIDRADENITIS SUPPURATIVA

Avsola<sup>®</sup>, Hadlima<sup>™</sup>, Humira<sup>®</sup>, Inflectra<sup>®</sup>, infliximab, Renflexis<sup>®</sup>, Remicade<sup>®</sup>, Cosentyx<sup>®</sup>

**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. 1<sup>st</sup> Line Preferred Agents:**
  - A. Hadlima<sup>™</sup> (adalimumab-bwwd)
  - B. Infliximab products: Avsola<sup>®</sup> (infliximab-axxq), Inflectra<sup>®</sup> (infliximab-dyyb), infliximab, Remicade (infliximab), Renflexis<sup>®</sup> (infliximab-abda)
- 2. 2nd line preferred agents with single step; after trial and failure of BOTH Hadlima and a preferred infliximab agent:**
  - A. Humira<sup>®</sup> (adalimumab)
- 3. Non-formulary Agents; after trial and failure of BOTH an adalimumab product and a preferred infliximab agent:**
  - A.  Cosentyx<sup>®</sup> (secukinumab)

**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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Is the requesting provider a dermatologist or in consultation with a dermatologist?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Has smoking cessation, weight management, diet, and proper hygiene counseling been discussed with the member?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Has the member had an inadequate response to ≥ 90 day trial of oral antibiotics, unless contraindicated?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Has the provider performed tuberculosis (TB) screening prior to therapy initiation?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

6. Has the provider performed hepatitis B screening prior to therapy initiation?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>COSENTYX®</b>			
1. Has the member tried and failed, or have a contraindication to an adalimumab product and an infliximab product?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Has baseline lesion count been documented?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. If the request is for 300mg every 14 days, does documentation show the following: <ul style="list-style-type: none"> <li>Member has been compliant with 300 mg dosing every 28 days for at least 16 weeks; AND</li> <li>Clinical documentation shows a positive, yet limited response to therapy?</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>REAUTHORIZATION</b>			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Has the provider performed continued tuberculosis monitoring during therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Has the provider performed continued Hepatitis B monitoring in HBV carriers?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
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: 01/17/2024  
Next Review Date: 01/17/2025  
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# HEALTH | CHOICE

UTAH

## PRIOR AUTHORIZATION REQUEST FORM

### HYPERKALEMIA

Lokelma<sup>®</sup>, Veltassa<sup>®</sup>

**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:**  Veltassa<sup>®</sup> (patiomer)

**Non-Preferred:**  Lokelma<sup>®</sup> (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?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the member between the ages of 18-80?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Is the request from, or in consultation with, a nephrologist or a cardiologist, or is the member pending hospital discharge?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Does the member have a serum potassium level between 5.5-6.5 mmol/L on two separate screenings?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please Provide Documentation</b>
5. If applicable, has the member tried dietary consultations to limit potassium intake?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please Provide Documentation</b>
6. If applicable, has the member tried discontinuing non-steroidal anti-inflammatories?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please Provide Documentation</b>
7. If applicable, has the member tried discontinuing potassium supplements?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please Provide Documentation</b>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please Provide Documentation</b>
9. Has the member had a trial and failure of a loop or thiazide diuretic (excluding potassium-sparing diuretics)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please Provide Documentation</b>

10. Is the requested medication being used to bridge a member with stage 5 kidney dysfunction to dialysis?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>REAUTHORIZATION</b>			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does updated clinical documentation show that the member's serum potassium is <5.5 mmol/L secondary to the use of patiromer (Veltassa)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please Provide Documentation</b>
<b>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.</b>			
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: 02/17/2023  
 Next Review Date: 02/17/2024  
 Current Effective Date: 03/01/2023

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# 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?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the requesting provider a gastroenterologist?	<input type="checkbox"/>	<input type="checkbox"/>	
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.)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Has the member had a trial and failure of, or contraindication to, at least one antidiarrheal (e.g. loperamide, diphenoxylate)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Has the member had a trial and failure of, or contraindication to, at least one antispasmodic (e.g. dicyclomine, hyoscyamine)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Has the member had a trial and failure of, or contraindication to, at least one tricyclic antidepressant (e.g. imipramine, desipramine)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
7. For alosetron hydrochloride: Does the member have any of the following: <ul style="list-style-type: none"> <li>History of chronic or severe constipation</li> <li>History of intestinal obstruction, stricture, toxic megacolon, gastrointestinal perforation and/or adhesions</li> <li>History of ischemic colitis, impaired intestinal circulation, ulcerative colitis, or Crohn's disease</li> <li>Active diverticulitis or a history of diverticulitis</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	

• Concomitant use of fluvoxamine			
<b>REAUTHORIZATION</b>			
1. Is the request for reauthorization?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does updated clinical documentation show continued medical necessity and disease stabilization or improvement of disease?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Please note: rifampin will only be approved for a maximum of three 14-day courses.	<input type="checkbox"/>	<input type="checkbox"/>	
<b>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.</b>			
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

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# 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?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the request for the preferred product Fasenra®?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Does documentation show the member's baseline eosinophil count?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Is the member being followed by an asthma specialist (e.g. allergist, immunologist, or pulmonologist)?	<input type="checkbox"/>	<input type="checkbox"/>	
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Does the member have poor asthma control, defined as two or more acute exacerbations in the past 12 months requiring additional medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
7. Does documentation show the member's forced expiratory volume (FEV1) is < 80%?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
8. Are underlying conditions or triggers for asthma or pulmonary disease maximally managed?	<input type="checkbox"/>	<input type="checkbox"/>	
9. Is the member an active smoker? If yes, does documentation show that smoking cessation has been addressed?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

### REAUTHORIZATION

1. Is the request for reauthorization?	<input type="checkbox"/>	<input type="checkbox"/>	
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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.?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
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: 11/09/2023  
 Next Review Date: 11/09/2024  
 Current Effective Date: 12/01/2023

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# 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
<b>INSULIN-LIKE GROWTH HORMONE FACTOR-1 DEFICIENCY</b>			
1. Does the member have a diagnosis of growth failure with severe primary insulin-like growth factor-1 deficiency (IGFD)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Is the member between the ages of 2-17?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Is the requesting provider a pediatric endocrinologist or in consultation with one?	<input type="checkbox"/>	<input type="checkbox"/>	
4. If 15 years of age or older, does the member have open growth plates confirmed by radiographic imaging?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Is the member's height standard deviation score less than or equal to -3.0 for age and sex?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>GROWTH HORMONE GENE DELETION</b>			
1. Does the member have growth failure with growth hormone gene deletion and has developed neutralizing antibodies to growth hormone?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Is the member between the ages of 2-17?	<input type="checkbox"/>	<input type="checkbox"/>	

3. Is the requesting provider a pediatric endocrinologist or in consultation with one?	<input type="checkbox"/>	<input type="checkbox"/>	
4. If 15 years of age or older, does the member have open growth plates confirmed by radiographic imaging?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>REAUTHORIZATION</b>			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. If 15 years of age or older, does the member have open growth plates confirmed by radiographic imaging?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Has the member experienced a growth velocity of $\geq 2$ cm total growth in 1 year?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Has the member reached final adult height?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
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: 05/11/2023  
 Next Review Date: 05/11/2024  
 Current Effective Date: 06/01/2023

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# HEALTH | CHOICE

UTAH

## PRIOR AUTHORIZATION REQUEST FORM

### CHRONIC INSOMNIA MEDICATIONS

Belsomra®, Dayvigo®, Rozerem®, doxepin

**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:		
<p><b>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.</b></p>		
<p><b>Product being requested:</b> <input type="checkbox"/> Belsomra® (suvorexant), <input type="checkbox"/> Dayvigo®(lemborexant), <input type="checkbox"/> Rozerem® (ramelteon), <input type="checkbox"/> doxepin (3mg, 6mg)</p>		
<p>Dosing/Frequency: _____</p>		

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

Questions	Yes	No	Comments/Notes
1. Has the member been diagnosed with chronic insomnia?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Is the member 18 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Does the member have functional distress or impairment caused by poor sleep?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Has the member experienced poor sleep for at least 3 nights per week for at least 3 months?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Is the sleep disorder related to medication or other mental disorders?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Have the following causes been ruled out: obstructive sleep apnea, chronic obstructive pulmonary disease, depression and anxiety?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
7. Has the member had cognitive behavioral therapy to treat insomnia for at least 3 months?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
8. Has the member had at least a 3-month trial and failure of, or contraindication to, over-the-counter sleep aids (e.g. melatonin, diphenhydramine, or doxylamine)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
9. Has the member had at least a 3-month trial and failure of, or contraindication to at least one generic antidepressant (e.g. amitriptyline, trazodone, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

10. Has the member had at least a 3-month trial and failure of, or contraindication to at least 1 generic non-benzodiazepine hypnotic medication (e.g. zolpidem, zaleplon, eszopiclone)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
11. If the request is for Belsomra® (suvorexant), has the member tried and failed, or have a contraindication/intolerance to Dayvigo® (lemborexant)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
12. If the request is for doxepin 3mg or 6mg, has the member tried and failed generic doxepin 10mg for at least 3-months with an inadequate response?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>REAUTHORIZATION</b>			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does the member meet at least two of the following: <ul style="list-style-type: none"> <li>• Time to onset of sleep has improved, total time asleep has improved, number of night awakenings reducing quality of sleep has improved</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Has the member experienced significant adverse effects from the therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
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- 038  
Origination Date: 01/01/2022  
Reviewed/Revised Date: 01/27/2022  
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# 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?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member had urinary tract symptoms for more than 6 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide baseline voiding symptoms and pain levels</b>
3. Does the member have a urinalysis or urine culture that rules out a urinary tract infection (UTI)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Have other identifiable causes been ruled out (e.g. overactive bladder, endometriosis and vulvodynia, and prostatitis)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Is the request made by, or in consultation with, a urologist?	<input type="checkbox"/>	<input type="checkbox"/>	
6. Has the member participated in conservative treatments (e.g. stress management, pain management, and self-care/behavioral modification)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
7. Has the member had a trial and failure of, or intolerance/contraindication to, amitriptyline and/or cimetidine?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

### RIMSO-50

1. Is the request for RIMSO-50®?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has heparin or lidocaine been trialed?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

### ELMIRON

1. Is the request for Elmiron®?	<input type="checkbox"/>	<input type="checkbox"/>	
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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)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>REAUTHORIZATION</b>			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the medication shown efficacy, defined as improvement in baseline voiding symptoms and pain levels?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
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: 03/16/2023  
 Next Review Date: 03/16/2024  
 Current Effective Date: 04/01/2023

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# HEALTH CHOICE

UTAH

## PRIOR AUTHORIZATION REQUEST FORM JUVENILE IDIOPATHIC ARTHRITIS MEDICATIONS

Actemra®, Avsola®, Enbrel®, Hadlima™, Humira®, Inflectra®,  
infliximab, Orenzia®, Remicade®, Renflexis®, 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:**

- 1st Line Preferred Agents:**
  - Hadlima™ (adalimumab-bwvd)
  - Infliximab products: [Avsola® (infliximab-axxq), Inflectra® (infliximab-dyyb), infliximab, Remicade (infliximab), Renflexis® (infliximab-abda)], Actemra® (tocilizumab), Orenzia® (abatacept)
- 2nd line preferred agents with single step; after trial and failure of BOTH Hadlima and a preferred infliximab agent:**
  - Humira® (adalimumab), Xeljanz®/Xeljanz XR® (tofacitinib)
- Non-Formulary Brands with a triple step; after trial and failure of BOTH Hadlima and a preferred infliximab agent and 2 second line agents:**
  - Enbrel® (etanercept)

**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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Is the requesting prescriber a rheumatologist or working in consultation with a rheumatologist?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Has the provider performed tuberculosis (TB) screening prior to therapy initiation?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

4. If the request is for a Tumor Necrosis Factor Inhibitor or Orenzia®, has the provider performed hepatitis B screening prior to therapy initiation?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. If the request is for Xeljanz/XR, does documentation show an 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 Xeljanz/XR in combination with a potent immunosuppressant (e.g., azathioprine or cyclosporine)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>ACTIVE JOINT COUNT ≤ 4 WITHOUT SYSTEMIC FEATURES</b>			
1. Does the member have an active joint count of ≤ 4 <i>without</i> systemic features?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Has the member had an adequate trial of, or intolerance/contraindication to, a nonsteroidal anti-inflammatory drug (NSAID)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Has the member had an adequate trial of, or intolerance/contraindication to, methotrexate or leflunomide?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Is the request for the preferred product, Humira®?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>ACTIVE JOINT COUNT &gt; 4 WITHOUT SYSTEMIC FEATURES</b>			
1. Does the member have an active joint count of > 4 <i>without</i> systemic features?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Has the member had a 3-month trial of, or intolerance/contraindication to, methotrexate or leflunomide?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>MILD TO MODERATE ACUTE DISEASE WITH SYSTEMIC FEATURES</b>			
1. Does the member have mild to moderate acute disease with systemic features of nondisabling symptoms without evidence of macrophage activation syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Has the member had an adequate trial of, or intolerance/contraindication to, a nonsteroidal anti-inflammatory drug (NSAID)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>MODERATE TO SEVERE ACUTE DISEASE WITH SYSTEMIC FEATURES</b>			
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (JIA)</b>			
1. Does the member have mild to moderate systemic JIA?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Has the member had an adequate trial of NSAIDs?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Does the member have moderate to severe systemic JIA?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>REAUTHORIZATION</b>			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member's therapy been re-evaluated within the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Has the therapy shown to be tolerable and effective with a decrease or stabilization in disease severity?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Does the member show a continued medical need for the therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Has the provider performed continued tuberculosis monitoring during therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

6. Has the provider performed continued Hepatitis B monitoring in HBV carriers?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
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: 09/14/2023  
 Next Review Date: 09/14/2024  
 Current Effective Date: 10/01/2023

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# 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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Is the member 18 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Is the prescriber a neurologist or working in consultation with a neurologist?	<input type="checkbox"/>	<input type="checkbox"/>	

<b>H.P. ACTHAR GEL®</b>			
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>OCREVUS®</b>			
1. Does the member have a diagnosis of primary progressive multiple sclerosis?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>REAUTHORIZATION</b>			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member's therapy been re-evaluated with a neurologist within the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Has the therapy shown to be effective with evidence of a positive clinical response?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Does the member show a continued medical need for therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
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: 11/09/2023  
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# 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?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the prescriber a pulmonologist or a physician with expertise in caring for cystic fibrosis patients?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Has the member had a trial and failure to hypertonic saline?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. If requesting twice daily dose of Pulmozyme®, has the member trialed once daily dosing?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

### REAUTHORIZATION

1. Is the request for reauthorization of therapy?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
2. Has the member's therapy been re-evaluated within the past 6 months?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Has the therapy shown to be effective with an improvement or stabilization in condition?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Does the member show a continued medical need for the therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

**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: 07/31/2023  
Next Review Date: 07/31/2024  
Current Effective Date: 08/01/2023

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# 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?	<input type="checkbox"/>	<input type="checkbox"/>	
2. If serum ferritin levels are $\leq 75$ mcg/L, has the member had a 3-month trial and failure of oral iron?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Has the patient tried and failed all of the following: ropinirole, pramipexole, pregabalin?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Is the patient unable to take medications by mouth or is oral therapy clinically inappropriate?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

### REAUTHORIZATION

1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Do updated progress notes show continued medical necessity and clinical efficacy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

**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

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

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

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4. Has a random drug screen been performed within the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Do the member's medication records correspond with medical reasons for continuing or modifying opioid therapy (i.e., medication, dose, and quantities prescribed)?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>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.</b>			
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: 11/09/2023  
 Next Review Date: 11/09/2024  
 Current Effective Date: 12/01/2023

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# 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:

**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:** \_\_\_\_\_

**Acute opioid coverage is limited to 7 days of therapy within any 60 days. Quantity limits and dose limits apply for acute opioid therapy. Long-acting opioids are not covered for acute use.**

**Opioid use beyond 30 days will be subject to additional coverage criteria. Please refer to Chronic Opioids Policy.**

**Please answer the following:**

Questions	Yes	No	Comments/Notes
1. Does the member have a diagnosis of active cancer? <b>If documentation supports active cancer therapy, no additional questions are required.</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation, including names, dates, and durations of treatments</b>
3. Does the member require no more than 7-day supply, except dental use (limit to a 3 days supply)?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Does the member require continuous opioid use beyond 30 days? If yes, see Chronic Opioid Policy.	<input type="checkbox"/>	<input type="checkbox"/>	
5. Is the member new to the plan and currently taking chronic short-acting opioid therapy? If yes, see Chronic Opioid Policy.	<input type="checkbox"/>	<input type="checkbox"/>	

6. Does the member require long-acting opioid for acute pain treatment? If yes, see Chronic Opioid Policy.	<input type="checkbox"/>	<input type="checkbox"/>	
<b>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.</b>			
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: 11/09/2023  
 Next Review Date: 11/09/2024  
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# 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: <ul style="list-style-type: none"> <li>• Postmenopausal female with osteoporosis,</li> <li>• Male with primary or hypogonadal osteoporosis,</li> <li>• Osteoporosis likely caused by systemic glucocorticoid therapy?</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Is the member considered high risk for fracture, defined by meeting one of the following: <ul style="list-style-type: none"> <li>• History of recent fragility fracture or bone mineral density measurement showing osteoporosis (T-score <math>\leq</math> -2.5),</li> <li>• History of previous fractures and/or glucocorticoid use for at least 3 months and osteopenia (T-Score between -1 and -2.5)?</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Does the member have severe osteoporosis, defined as one of the following: <ul style="list-style-type: none"> <li>• T-score <math>\leq</math> -2.5 plus a recent fragility fracture</li> <li>• T-score <math>\leq</math> -3.5 and at high risk for fragility fracture based on FRAX score</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Does documentation show a 24-month trial and failure (defined as progression of bone loss) of at least one bisphosphonate (i.e.	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

alendronate, ibandronate, risedronate, intravenous zoledronic acid), unless contraindicated? <ul style="list-style-type: none"> <li>• IV therapy (zoledronic acid) is required if the member is unable to tolerate oral bisphosphonate or has an absorption disorder.</li> </ul>			
5. Does documentation show a 24-month trial and failure of Prolia®, unless contraindicated?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
Additional information:			
Physician's Signature:			

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

PHARM-HCU-054  
 Origination Date: 01/01/2022  
 Reviewed/Revised Date: 03/16/2023  
 Next Review Date: 03/16/2014  
 Current Effective Date: 04/01/2023

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# HEALTH | CHOICE

UTAH

## PRIOR AUTHORIZATION REQUEST FORM

### PHENYL BUTYRATES

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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Does documentation show that the member's condition has not been managed adequately by dietary protein restriction and/or amino acid supplementation alone?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Has a nutritional consultation been performed to assess diet?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Will phenylbutyrate be used in combination with a dietary protein restriction?	<input type="checkbox"/>	<input type="checkbox"/>	
5. Does the requesting provider have experience managing urea cycle disorder?	<input type="checkbox"/>	<input type="checkbox"/>	
6. Is the request for Ravicti®? <b>Please note: For Ravicti®, treatment failure for "bad taste" or "taste aversion" will only be allowed in members ≤11 years old.</b>	<input type="checkbox"/>	<input type="checkbox"/>	
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)	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does updated documentation show a continued medical necessity and clinical efficacy of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
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: 11/09/2023  
 Next Review Date: 11/09/2024  
 Current Effective Date: 12/01/2023

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# HEALTH | CHOICE

UTAH

## PRIOR AUTHORIZATION REQUEST FORM

### PHENYLKENTONUIRA

Kuvan<sup>®</sup>, Palynziq<sup>®</sup>

**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<sup>®</sup> (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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Is the member followed by a physician who specializes in metabolic diseases?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Is the member followed by a dietician who specializes in PKU/metabolic diseases?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Has the member been compliant with and failed a phenylalanine restricted diet for at least 6 months?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Do average Phe levels within 2 weeks of therapy initiation show the following? <ul style="list-style-type: none"> <li>• &gt;6 mg/dL for ages 1 month to 12 years</li> <li>• &gt;15 mg/dL after the age of 12</li> <li>• &gt;6 mg/dL in pregnancy.</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

#### PALYNZIQ<sup>®</sup>

1. Is sapropterin dihydrochloride or Palynziq <sup>®</sup> being requested to liberalize a strict phenylalanine restricted diet? Authorization will not be provided for liberalizing diet or in non-compliant patients.	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has a trial and failure of the maximally tolerated dose of sapropterin dihydrochloride been demonstrated?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

3. In women of childbearing potential, will contraception be used prior to and during treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>REAUTHORIZATION</b>			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member remained compliant with a phenylalanine-restricted diet?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Has there been a documented positive clinical response from treatment? <ul style="list-style-type: none"> <li>• Defined as a <math>\geq 20\%</math> decrease from baseline in Phe levels after 12 weeks or maintenance of initial reduction.</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
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: 01/17/2024  
 Next Review Date: 01/17/2025  
 Current Effective Date: 02/01/2024

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# HEALTH | CHOICE

UTAH

## PRIOR AUTHORIZATION REQUEST FORM PROMACTA®

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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
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**CHRONIC OR PERSISTENT IMMUNE/IDIOPATHIC THROMBOCYTOPENIA (ITP)**

1. Does the member have a diagnosis of chronic or persistent (>6 months) immune/idiopathic thrombocytopenia (ITP)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Does documentation show a platelet count < 30,000/mcL?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Is the requesting provider a hematologist or oncologist?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Has the member had a trial and failure of corticosteroids? <ul style="list-style-type: none"> <li>• 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</li> <li>• Failure is defined as platelet count not increasing to at least 50,000/mcL or continued requirement for steroids after 3 months of treatment</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

**CHRONIC HEPATITIS C- ASSOCIATED THROMBOCYTOPENIA**

1. Does the member have a diagnosis Chronic Hepatitis C-associated thrombocytopenia?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Is the requesting provider a gastroenterologist, infectious disease specialist, or a hematologist?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Is the member's platelet count < 75,000/mcL?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

<b>SEVERE APLASTIC ANEMIA</b>			
1. Does the member have a confirmed diagnosis of Severe Aplastic Anemia?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the requesting provider a hematologist?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Does documentation show bone marrow cellularity less than 25% or 25-50% if less than 30% of residual cells are hematopoietic?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Does documentation show at least two of the following? <ul style="list-style-type: none"> <li>• Absolute neutrophil count (ANC) &lt; 500/mL</li> <li>• Platelet count &lt; 20,000/mcL</li> <li>• Reticulocyte count &lt; 20,000/mcL</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Has the member had a 3-month trial and failure of standard immunosuppressive therapy (e.g. cyclosporine, anti-thymocyte globulin, or cyclophosphamide)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>PROMACTA PACKETS FOR SUSPENSION</b>			
1. Is the member less than 8 years of age?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does documentation show the member is unable to swallow or has severe dysphagia preventing the member from taking solid oral medications?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>REAUTHORIZATION</b>			
<b>CHRONIC OR PERSISTENT IMMUNE/IDIOPATHIC THROMBOCYTOPENIA (ITP)</b>			
1. Is the request for reauthorization of therapy for ITP?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member responded to therapy, defined as a platelet count of at least 50,000/mcL?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>CHRONIC HEPATITIS C- ASSOCIATED WITH THROMBOCYTOPENIA</b>			
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>SEVERE APLASTIC ANEMIA</b>			
1. Is the request for reauthorization of therapy for severe aplastic anemia?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member responded to therapy, defined as at least one of the following? <ul style="list-style-type: none"> <li>• Platelet increase of at least 20,000/mcL above baseline</li> <li>• Transfusion independent and stable platelet counts for at least 8 weeks</li> <li>• Hemoglobin increase by at least 1.5g/dL</li> <li>• Reduction in red blood cell transfusions of at least 4 units for at least 8 weeks</li> <li>• Absolute neutrophil count increase of 100% or increase of at least 500/mcL</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
Additional information:			

Physician's Signature:

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Policy PHARM-HCU-060  
Origination Date: 01/01/2022  
Reviewed/Revised Date: 05/11/2023  
Next Review Date: 05/11/2024  
Current Effective Date: 06/01/2023

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# HEALTH CHOICE

UTAH

## PRIOR AUTHORIZATION REQUEST FORM

### PSORIASIS

Avsola<sup>®</sup>, Bimzelx<sup>®</sup>, Cimzia<sup>®</sup>, Hadlima<sup>™</sup>, Humira<sup>®</sup>, Inflectra<sup>®</sup>, infliximab, Otezla<sup>®</sup>, Remicade<sup>®</sup>, Renflexis<sup>®</sup>, Taltz<sup>®</sup>

**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<sup>st</sup> Line Preferred Agents:**
  - A. Hadlima<sup>™</sup> (adalimumab-bwwd)
  - B. Infliximab products: Avsola<sup>®</sup> (infliximab-axxq), Inflectra<sup>®</sup> (infliximab-dyyb), infliximab, Remicade (infliximab), Renflexis<sup>®</sup> (infliximab-abda)
- 2nd line preferred agents with single step; after trial and failure of BOTH Hadlima and a preferred infliximab agent:**
  - A. Cimzia<sup>®</sup> (certolizumab), Humira<sup>®</sup> (adalimumab), Otezla<sup>®</sup> (apremilast), Taltz<sup>®</sup> (ixekizumab)
- 3. Non-Formulary Agents with a triple step; after trial and failure of BOTH Hadlima and a preferred infliximab agent and 2 second line agents:**
  - A. Bimzelx<sup>®</sup> (bimekizumab), Cosentyx<sup>®</sup> (secukinumab), Enbrel<sup>®</sup> (etanercept), Ilumya<sup>®</sup> (tildrakizumab), Siliq<sup>™</sup> (brodalumab), Stelara<sup>®</sup> (ustekinumab), Skyrizi<sup>®</sup> (risankizumab-rzaa), Sotyktu<sup>™</sup> (deucravacitinib), Spevigo<sup>®</sup> (spesolimab), Tremfya<sup>®</sup> (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?	<input type="checkbox"/>	<input type="checkbox"/>	
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%) <b>OR</b> high impact disease (plaques on palms/soles, scalp psoriasis, nail psoriasis)? <b>Note:</b> Otezla does not require documentation of severity	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

3. Has the member had an adequate trial and failure of, or contraindication to, phototherapy or photochemotherapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Has the provider performed tuberculosis (TB) screening prior to therapy initiation? (Note: NOT required if the request is for Otezla)	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. If the request is for a Tumor Necrosis Factor Inhibitor, has the provider performed hepatitis B screening prior to therapy initiation?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>REAUTHORIZATION</b>			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member's therapy been re-evaluated within the past 6 months?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Has the therapy shown to be tolerable and effective with an improvement in condition?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Does the member show a continued medical need for the therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Has the provider performed continued tuberculosis monitoring during therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Has the provider performed continued Hepatitis B monitoring in HBV carriers?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
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: 05/22/2024  
 Next Review Date: 05/22/2025  
 Current Effective Date: 06/01/2024

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# HEALTH CHOICE

UTAH

## PRIOR AUTHORIZATION REQUEST FORM

### PSORIATIC ARTHRITIS

Avsola®, Cimzia®, Cosentyx®, Enbrel®, Hadlima™, Humira®, Inflectra®, infliximab, Orenzia®, Otezla®, Remicade®, Renflexis®, Rinvoq®, Simponi®, Stelara®, Skyrizi®, Taltz®, Tremfya®, Xeljanz/XR®

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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. 1<sup>st</sup> Line Preferred Agents:**
  - A. Hadlima™ (adalimumab-bwwd)
  - 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 and a preferred infliximab agent:**
  - A. Cimzia® (certolizumab), Humira® (adalimumab), Orenzia® (abatacept), Otezla® (apremilast), Taltz® (ixekizumab), Xeljanz/XR® (tofacitinib)
- 3. Non-Formulary Agents with a triple step; after trial and failure of BOTH Hadlima and a preferred infliximab agent and 2 second line agents:**
  - A. Cosentyx® (secukinumab), Enbrel® (etanercept), Rinvoq® (upadacitinib), Skyrizi® (risankizumab-rzaa) Simponi® (golimumab), Stelara® (ustekinumab), 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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Is the request from, or in consultation with, a rheumatologist or a dermatologist?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Has the patient had an adequate trial and failure of at least one of the following disease-modifying antirheumatic drugs	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

(DMARDs), unless contraindicated to all: methotrexate, leflunomide, sulfasalazine, azathioprine, intra-articular glucocorticoid injections, hydroxychloroquine, D-penicillamine, or minocycline?			
4. Does the member have moderate axial disease, severe disease, or enthesitis? <ul style="list-style-type: none"> <li>For patients with moderate axial disease, severe disease, or enthesitis, a trial and failure of a DMARD may not be necessary.</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. If the request is for Xeljanz/XR®, does documentation show inadequate response or intolerance to at least one TNF (tumor necrosis factor) blocker such as an infliximab product, Cimzia, Humira 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)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
7. If the request is for a Tumor Necrosis Factor Inhibitor, has the provider performed hepatitis B screening prior to therapy initiation?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>REAUTHORIZATION</b>			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member's therapy been re-evaluated within the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Has the therapy shown to be tolerable and effective with a significant decrease in disease severity?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Does the member show a continued medical need for the therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Has the provider performed continued tuberculosis monitoring during therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Has the provider performed continued Hepatitis B monitoring in HBV carriers?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
Additional information:			

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Physician's Signature:

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Policy: PHARM-HCU-062  
Origination Date: 01/01/2022  
Reviewed/Revised Date: 09/14/2023  
Next Review Date: 09/14/2024  
Current Effective Date: 10/01/2023

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# 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.**

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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:**  Adempas® (riociguat),  ambrisentan,  bosentan,  epoprostenol,  Opsumit® (macitentan),  Orenitram® tablets,  treprostinil intravenous,  Uptravi® (selexipag)

**Non-preferred:**  Ventavis® solution for inhalation

**Non-Formulary:**  Remodulin® (treprostinil),  Tracleer® (bosentan),  Tyvaso® solution for inhalation

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)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Is the member classified as WHO (World health Organization) Group 1 pulmonary arterial hypertension? If not, please provide the WHO group classification.	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Is the requesting provider a cardiologist or pulmonologist specializing in pulmonary hypertension?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Does the member have regular follow up visits with the prescriber?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Has the member demonstrated at least 80% compliance with pulmonary hypertension medications?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

7. Has the member performed a baseline 6-minute walk test?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
8. Is the member currently smoking or vaping?	<input type="checkbox"/>	<input type="checkbox"/>	
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>ENDOTHELIN RECEPTOR ANTAGONISTS: AMBRISENTAN, BOSENTAN, OPSUMIT®</b>			
1. Will the medication be used in combination with a phosphodiesterase inhibitor?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. If the request is for Opsumit®, has ambrisentan been trialed and failed?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>PROSTACYCLIN PATHWAY AGONISTS: ORENITRAM®, TREPROSTINIL IV, TREPROSTINIL SQ, REMODULIN®, TYVASO®, UPTRAVI®, VENTAVIS®</b>			
1. Does the following apply: Has the member tried and failed a PDE5 inhibitor in combination with ambrisentan or bosentan or does clinical documentation show a medical reason why the member cannot? • Is the member in WHO functional class III or IV?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. For Tyvaso® and Ventavis® only, has the member had a trial and failure to treprostinil IV or SQ?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>GUANYLATE CYCLASE STIMULATOR: ADEMPAS®</b>			
1. Is the member in WHO functional class II, III or IV?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Does the member have a clinical diagnosis of WHO Group 4 PAH after surgical treatment OR have confirmed inoperable chronic thromboembolic pulmonary hypertension?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>REAUTHORIZATION</b>			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does documentation show disease improvement or stabilization (e.g. improvement in 6 minute walk test, functional class, pulmonary arterial pressure, cardiac index, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
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  
Current Effective Date: 12/01/2023

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# HEALTH CHOICE

UTAH

## PRIOR AUTHORIZATION REQUEST FORM

### RHEUMATOID ARTHRITIS

Actemra®, Avsola®, Cimzia®, Enbrel®, Hadlima™, Humira®, Inflectra®, Kevzara®, Kineret®, Olumiant®, Orenzia®, Remicade®, Renflexis®, Riabni®, Rinvoq®, Rituxan®, Ruxience®, Simponi®, Truxima®, 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. 1<sup>st</sup> Line Preferred Agents:

- Hadlima™ (adalimumab-bwwd)
- Infliximab products: Avsola® (infliximab-axxq), Inflectra® (infliximab-dyyb), infliximab, Remicade (infliximab), Renflexis® (infliximab-abda)
- Rituximab biosimilar products: Riabni® (rituximab-arxx), Ruxience® (rituximab-pvvr), Truxima® (rituximab-abbs)

##### 2. 2nd line preferred agents with single step; after trial and failure of BOTH Hadlima and a preferred infliximab agent:

- Actemra® (tocilizumab), Cimzia® (certolizumab), Humira® (adalimumab), Kevzara® (sarilumab), Kineret® (anakinra), Olumiant® (baricitinb), Orenzia® (abatacept), Xeljanz/XR® (tofacitinib)

##### 3. Non-Formulary Agents with a triple step; after trial and failure of BOTH Hadlima and a preferred infliximab agent and 2 second line agents:

- Enbrel® (etanercept), 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?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the requesting provider a rheumatologist or in consultation with a rheumatologist?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Is the patient's condition moderate to severe based on the Disease Activity Score (DAS28) or is a tender and swollen joint count provided as well as C-reactive protein (CRP) or erythrocyte sedimentation rate (ESR)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

4. 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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. 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, Humira 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)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
7. If the request is for a Tumor Necrosis Factor Inhibitor, has the provider performed hepatitis B screening prior to therapy initiation?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>REAUTHORIZATION</b>			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the patient experienced at least a 20% improvement in ACR or DAS28 score since therapy initiation?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Has the provider performed continued tuberculosis monitoring during therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Has the provider performed continued Hepatitis B monitoring in HBV carriers?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
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: 09/14/2023  
 Next Review Date: 09/14/2024  
 Current Effective Date: 10/01/2023

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# 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.**

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- 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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>ACROMEGALY</b>			
2. Has the member had an inadequate response or contraindication to surgery or radiation?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Has the member had an inadequate response or contraindication to a dopamine agonist (i.e., bromocriptine, cabergoline)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>METASTATIC CARCINOID TUMORS</b>			
1. Does the member have severe diarrhea and flushing associated with metastatic carcinoid tumors?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>VASOACTIVE INTESTINAL PEPTIDE TUMOR (VIPoma)</b>			
1. Does the member have profuse watery diarrhea associated with a Vasoactive Intestinal Peptide Tumor (VIPoma)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>Gastrointestinal Arterio-Venous Malformations (HEYDE'S SYNDROME)</b>			
1. Is the request for gastrointestinal arteriovenous malformations (e.g. Heyde's Syndrome)?	<input type="checkbox"/>	<input type="checkbox"/>	

NEUROENDOCRINE TUMORS			
1. Is the request for neuroendocrine tumors and in accordance with NCCN guidelines?	<input type="checkbox"/>	<input type="checkbox"/>	
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?	<input type="checkbox"/>	<input type="checkbox"/>	
HIGH OUTPUT FISTULAS			
1. Is the request for high output fistulas?	<input type="checkbox"/>	<input type="checkbox"/>	
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the therapy shown to be effective with a clinically significant response to therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Does the member show a continued medical need for the therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
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: 09/14/2023  
 Next Review Date: 09/14/2024  
 Current Effective Date: 10/01/2023

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# 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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Is the member 18 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Has the member had a 3-month trial and failure or contraindication to each of the following: <ul style="list-style-type: none"> <li>• pregabalin</li> <li>• Tricyclic antidepressants (i.e. amitriptyline)</li> <li>• duloxetine</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

#### REAUTHORIZATION

1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does clinical documentation show continued medical necessity and that the member has responded to treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

**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: 03/16/2023  
Next Review Date: 03/16/2024  
Current Effective Date: 04/01/2023

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# HEALTH CHOICE

UTAH

## PRIOR AUTHORIZATION REQUEST FORM

### OCALIVA®

**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:**  Ocaliva® (obeticholic acid)

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 primary biliary cholangitis (PBC)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Is the member 18 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Is the request made by, or in consultation with, a hepatologist or gastroenterologist?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Does the member have documentation of both of the following: <ul style="list-style-type: none"> <li>A positive AMA (antimitochondrial antibody) titer (&gt; 1:40) on immunofluorescence OR M2 positive by enzyme-linked immunosorbent assay OR PBC-specific antinuclear antibodies, if AMA is negative?</li> <li>History of elevated ALP (alkaline phosphatase) levels <math>\geq</math> 1.5 times the upper limit of normal for <math>\geq</math> 6 months OR liver biopsy showing histological evidence of PBC?</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Do documented laboratory values show at least one of the following: <ul style="list-style-type: none"> <li>ALP levels <math>\geq</math> 1.67 times the upper limit of normal</li> <li>Total bilirubin &gt; the upper limit of normal, but &lt; 2 times the upper limit of normal</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

6. Has member had a trial and failure or intolerance/contraindication to ursodeoxycholic acid (ursodiol /UDCA) at a dose of 13 to 15mg/kg/day for at least 12 months? <ul style="list-style-type: none"> <li>• Failure to UDCA defined as ALP <math>\geq</math> 1.67x ULN</li> <li>• Intolerance to UDCA must be unable to be resolved with attempts to minimize the adverse effects where appropriate (e.g. dose reduction)</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
7. Will Ocaliva® be used in combination with UDCA unless contraindicated/intolerant?	<input type="checkbox"/>	<input type="checkbox"/>	
8. Does the member have a complete biliary obstruction?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
9. Does the member have clinical complications of PBC or clinically significant hepatic decompensation including, but not limited to, the following? <ul style="list-style-type: none"> <li>• Liver transplant, current placement on a liver transplant list, current Model for End Stage Liver disease (MELD) score <math>\geq</math> 15, known esophageal varices, poorly controlled or diuretic resistant ascites, history of variceal bleeds or related interventions (e.g. beta blockers, bands, or shunt), hepatic encephalopathy, spontaneous bacterial peritonitis, hepatocellular carcinoma, bilirubin &gt; 2 times the upper limit of normal, hepatorenal syndrome, serum creatinine &gt; 2mg/dL, or advanced cirrhosis</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>REAUTHORIZATION</b>			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the biomedical response assessed after 1 year showing the following? <ul style="list-style-type: none"> <li>• Bilirubin levels <math>\leq</math> ULN</li> <li>• ALP &lt; 1.67x the ULN</li> <li>• ALP decrease of <math>\geq</math> 15% from baseline</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Has member developed clinically significant liver-related adverse reactions?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>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.</b>			
Additional information:			
Physician 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: 07/31/2023  
 Next Review Date: 07/31/2024  
 Current Effective Date: 08/01/2023

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# 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
<b>SPRAVATO™</b>			
1. Is the member 18 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does the member have a diagnosis of moderate to severe major depressive disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. If the member is prescribed an antidepressant, has the member been compliant?	<input type="checkbox"/>	<input type="checkbox"/>	
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Has the member had an inadequate response to intravenous ketamine treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Has the member had an inadequate response to Electroconvulsive therapy (ECT)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
7. Does the member have a recent history of substance abuse or alcohol use disorder?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>REAUTHORIZATION</b>			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. If the member is prescribed an antidepressant, has the member been compliant?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Does clinical documentation show continued medical necessity and a positive clinical response?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

**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: 01/19/2023  
Next Review Date: 01/19/2024  
Current Effective Date: 04/01/2023

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# HEALTH CHOICE

UTAH

## PRIOR AUTHORIZATION REQUEST FORM

### SUBCUTANEOUS METHOTREXATE

Otrexup®, Rasuvo®, RediTrex™

**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:**  RediTrex™ (methotrexate)

**Non-preferred:**  Otrexup® (methotrexate),  Rasuvo™ (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?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member had a trial and failure with oral methotrexate?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Has the member had a trial and failure, with subcutaneous or intramuscular methotrexate?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

#### REAUTHORIZATION

1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member's therapy been re-evaluated within the past 6 months?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Has the therapy shown to be tolerable and effective with an improvement in condition?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Does the member show a continued medical need for the therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

**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: 07/31/2023  
Next Review Date: 07/31/2024  
Current Effective Date: 08/01/2023

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# HEALTH CHOICE

UTAH

## PRIOR AUTHORIZATION REQUEST FORM

### BRAND STATINS

Altoprev®, FloLipid®, Livalo®

**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:**  Altoprev® (lovastatin extended-release),  FloLipid® (simvastatin suspension),  Livalo® (pitavastatin)

Dosing/Frequency: \_\_\_\_\_

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

Questions	Yes	No	Comments/Notes
<b>ALTOPREV®</b>			
1. Is the request for Altoprev®?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the request for the treatment of primary hypercholesterolemia, primary or secondary prevention of cardiovascular events, or to slow coronary atherosclerosis progression?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Has the member had a 90 day trial and failure or intolerance of at least 4 other generic statin therapies (e.g. simvastatin, atorvastatin, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Has the member had a 90 day trial and failure of ezetimibe?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>FLOLIPID®</b>			
1. Is the request for FloLipid®?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the request for treatment of primary hypercholesterolemia, hypertriglyceridemia, primary dysbetalipoproteinemia, homozygous familial hyperlipidemia, primary or secondary prevention of cardiovascular events, or heterozygous familial hypercholesterolemia in adolescent patients?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Is the member unable to swallow or has severe dysphagia that prevents the member from taking solid oral dosage forms?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

<b>LIVALO®</b>			
1. Is the request for Livalo®?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the request for treatment of primary hypercholesterolemia or hypertriglyceridemia?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Has the member had a 90 day trial and failure or intolerance of at least 4 other high-intensity generic statin therapies (e.g. rosuvastatin, atorvastatin)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Has the member had a 90 day trial and failure of ezetimibe?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>REAUTHORIZATION</b>			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the therapy shown to be effective with an improvement in condition?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Does the member show a continued medical need for the therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
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-071  
 Origination Date: 01/01/2022  
 Reviewed/Revised Date: 05/11/2023  
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## 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:	
<b>Product being requested:</b> <input type="checkbox"/> 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 $\leq$ 12 months at the start of the RSV season? If no, skip to question #7.	<input type="checkbox"/>	<input type="checkbox"/>	
2. If the member is < 6 months of age, is Beyfortus (nirsevimab) available for administration?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Was the member born before 29 weeks, 0 days gestation? <ul style="list-style-type: none"> <li>• <i>Note: Synagis prophylaxis is not recommended for otherwise well infants <math>\geq</math> 29 weeks gestational age.</i></li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	
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?	<input type="checkbox"/>	<input type="checkbox"/>	
5. Is the member diagnosed with hemodynamically significant congenital heart disease with one of the following: <ul style="list-style-type: none"> <li>• Cyanotic heart disease, receiving medication to control congestive heart failure?; OR</li> <li>• Member will require cardiac surgical procedures?; OR</li> <li>• Member has moderate to severe pulmonary hypertension?</li> </ul> <i>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.</i>	<input type="checkbox"/>	<input type="checkbox"/>	
6. Does the member have anatomic pulmonary abnormalities or neuromuscular disorders that impairs the ability to clear secretions from the upper airway?	<input type="checkbox"/>	<input type="checkbox"/>	

7. Will the member be profoundly immunocompromised during the respiratory syncytial virus (RSV) season?	<input type="checkbox"/>	<input type="checkbox"/>	
8. Was the member's age $\geq$ 12 months and $<$ 24 months at the start of the RSV season?	<input type="checkbox"/>	<input type="checkbox"/>	
9. Is the member $<$ 20 months and expected to receive a heart transplant during the current RSV season?	<input type="checkbox"/>	<input type="checkbox"/>	
10. Is the member $<$ 20 months and expected to be profoundly immunocompromised during the current RSV season?	<input type="checkbox"/>	<input type="checkbox"/>	
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? <i>Note: Synagis prophylaxis is not recommended for otherwise well infants with chronic lung disease of prematurity who are 12 to 24 months old.</i>	<input type="checkbox"/>	<input type="checkbox"/>	
12. Has the member had a respiratory syncytial virus-related hospitalization during this RSV season?	<input type="checkbox"/>	<input type="checkbox"/>	
13. Has the member received Beyfortus during this RSV season?	<input type="checkbox"/>	<input type="checkbox"/>	
14. Was Synagis <sup>®</sup> given while the member was in the hospital (e.g., NBICU, NICU)? If yes, please list dates given: _____	<input type="checkbox"/>	<input type="checkbox"/>	
Physician's Signature:			

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

1. Synagis<sup>®</sup> (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<sup>®</sup> 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<sup>®</sup> therapy, may receive monthly doses until end date determined by the local State Health Department.
4. Synagis<sup>®</sup> therapy will not be approved with active RSV infection.
5. Synagis<sup>®</sup> prophylaxis will be discontinued if the member is hospitalized for RSV infection while being treated with monthly prophylaxis.
6. Synagis<sup>®</sup> therapy will be provided by the preferred pharmacy vendor.
7. Synagis<sup>®</sup> season information is available on the CDC website: <https://www.cdc.gov/surveillance/nrevss/rsv/state.html>

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# HEALTH CHOICE

UTAH

## PRIOR AUTHORIZATION REQUEST FORM

### ULCERATIVE COLITIS

Avsola<sup>®</sup>, Entyvio<sup>®</sup>, Hadlima<sup>™</sup>, Humira<sup>®</sup>, Inflectra<sup>®</sup>, infliximab, Remicade<sup>®</sup>, Renflexis<sup>®</sup>, Rinvoq<sup>®</sup>, Simponi<sup>®</sup>, Stelara<sup>®</sup>, Xeljanz<sup>®</sup>

**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<sup>st</sup> Line Preferred Agents:**
  - Hadlima<sup>™</sup> (adalimumab-bwwd)
  - Infliximab products: Avsola<sup>®</sup> (infliximab-axxq), Inflectra<sup>®</sup> (infliximab-dyyb), infliximab, Remicade (infliximab), Renflexis<sup>®</sup> (infliximab-abda)
- 2nd line preferred agents with single step; after trial and failure of BOTH Hadlima and a preferred infliximab agent:**
  - Entyvio<sup>®</sup> (vedolizumab) IV, Humira<sup>®</sup> (adalimumab), Xeljanz<sup>®</sup>/XR (tofacitinib)
- Non-Formulary Agents with a triple step; after trial and failure of BOTH Hadlima and a preferred infliximab agent and 2 second line agents:**
  - Rinvoq<sup>®</sup> (upadacitinib), Simponi<sup>®</sup> (golimumab), Stelara<sup>®</sup> (ustekinumab)
- Non-Formulary Agent after trial and failure of all the above:**
  - Entyvio<sup>®</sup> (vedolizumab) subcutaneous injection

Product being requested: \_\_\_\_\_

Dosing/Frequency: \_\_\_\_\_

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

Questions	Yes	No	Comments/Notes
<b>MODERATE TO SEVERE ULCERATIVE COLITIS</b>			
1. Has the member been diagnosed with moderate to severe Ulcerative Colitis?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Is the prescribing provider a gastroenterologist or in consultation with a gastroenterologist?	<input type="checkbox"/>	<input type="checkbox"/>	

3. Has the provider performed tuberculosis (TB) screening prior to therapy initiation?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Has the member had an adequate trial and failure of at least one of the following, or contraindication to all: <ul style="list-style-type: none"> <li>• High dose oral 5-aminosalicylic acid drug</li> <li>• Topical 5-aminosalicylic acid drug</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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, 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 )?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>SEVERE ULCERATIVE COLITIS</b>			
1. Has the member been diagnosed with severe Ulcerative Colitis? <ul style="list-style-type: none"> <li>• Has the patient had more than six stools per day with blood OR has systemic symptoms (fever, tachycardia, anemia or erythrocyte sedimentation rate &gt; 30mm/h)?</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Is the prescribing provider a gastroenterologist or in consultation with a gastroenterologist?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Has the provider performed tuberculosis (TB) screening prior to therapy initiation?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Has the provider performed hepatitis B screening prior to therapy initiation?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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 )?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>FULMINANT COLITIS</b>			
1. Has the member been diagnosed with fulminant colitis? <ul style="list-style-type: none"> <li>• Has the member had more than 10 bowel movements per day with continuous bleeding OR has colonic dilation, transfusion requirement, or toxicity?</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Is the prescribing provider a gastroenterologist or in consultation with a gastroenterologist?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Has the provider performed tuberculosis (TB) screening prior to therapy initiation?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Has the provider performed hepatitis B screening prior to therapy initiation?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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 )?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does updated clinical documentation show a positive response to therapy, such as a decrease or stabilization in the Disease Activity Index (DAI) score?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Has the provider performed continued tuberculosis monitoring during therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Has the provider performed continued Hepatitis B monitoring in HBV carriers?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
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  
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# HEALTH CHOICE

UTAH

## PRIOR AUTHORIZATION REQUEST FORM

### VMAT-2 INHIBITORS

Austedo®, Ingrezza®, tetrabenazine

**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:**  Austedo® (deutetrabenazine),  Ingrezza® (valbenazine),  tetrabenazine

Dosing/Frequency: \_\_\_\_\_

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

Questions	Yes	No	Comments/Notes
<b>TARDIVE DYSKINESIA</b>			
1. Is the request made by, or in consultation with, a psychiatrist or neurologist?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does documentation contain an Abnormal Involuntary Movement Scale (AIMS)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Does documentation contain a Clinical Global Impression of Severity (CGI-S)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Is the member currently taking reserpine or a MAO-I?	<input type="checkbox"/>	<input type="checkbox"/>	
5. For Ingrezza®, has the member had a 3-month trial and failure of a benzodiazepine and tetrabenazine?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. For Austedo®, has the member had a 3-month trial and failure of Ingrezza®?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>CHOREA ASSOCIATED WITH HUNTINGTON'S DISEASE</b>			
1. Is the request made by, or in consultation with, a neurologist?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does documentation include a diagnosis made by characteristic motor examination features and genetic testing?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Is the member ambulatory?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Has the member tried and failed at least two of the following: amantadine, an antipsychotic, riluzole, nabilone?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

5. For Austedo®, has the member had a 3-month trial and failure of tetrabenazine?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>TOURETTE SYNDROME</b>			
1. Have non-pharmacologic therapies been tried and found to be inadequate to meet treatment goals?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Has the member tried and failed at least 3 of the following medications: guanfacine, clonidine, topiramate, botulinum toxin, fluphenazine, haloperidol, risperidone, pimozide, aripiprazole?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>REAUTHORIZATION</b>			
1. Does clinical documentation show a continued medical need as well as medication efficacy defined as objective progress towards treatment plan goals?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. If the request for reauthorization of therapy for tardive dyskinesia, does clinical documentation show a continued medical need as well as medication efficacy defined by the AIMS score has decreased by at least 2 points from based line and the CGI-S score is ≤ 2?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. If the request is for reauthorization of therapy for Huntington’s disease, does updated documentation show disease stabilization and functional improvement of symptoms?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
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-076  
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# HEALTH | CHOICE

UTAH

## PRIOR AUTHORIZATION REQUEST FORM

### 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:**  Xifaxan® (rifaximin)

Dosing/Frequency: \_\_\_\_\_

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

Questions	Yes	No	Comments/Notes
<b>HEPATIC ENCEPHALOPATHY</b>			
1. Is the request for Hepatic Encephalopathy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Is the member 18 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Is the member currently using or severely intolerant to lactulose?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>IRRITABLE BOWEL SYNDROME WITH DIARRHEA (IBS-D)</b>			
1. Does the member have IBS-D with recurrent abdominal pain for at least 1 day/week in the last 3 months?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Is the abdominal pain associated with at least two of the following: related to defecation, associated with a change in frequency of stool, associated with a change in form/appearance of stool?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Is the prescriber a gastroenterologist?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Has the member shown trial and failure to nutritional and/or behavioral modifications (lactose restricted diet, gluten-free diet, low carb diet, elimination of fermentable oligo-di-monosaccharides and polyols (FODMAPS), increased physical activity)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Has the member shown trial and failure or contraindication to an antidiarrheal (loperamide, diphenoxylate)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

6. Has the member shown trial and failure or contraindication/intolerance to a tricyclic antidepressant (imipramine, despiramine)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
7. Has serologic testing been performed to rule out celiac disease?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
8. Does documentation show that fecal calprotectin and C-reactive protein have been checked to rule out inflammatory bowel disease?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>TRAVELER'S DIARRHEA</b>			
1. Is the request for Traveler's Diarrhea?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Is the member 12 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Is E. coli the suspected pathogen?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Has the member shown trial and failure or contraindication to a quinolone (e.g., ciprofloxacin, levofloxacin, ofloxacin)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>SMALL INTESTINAL BACTERIAL OVERGROWTH (SIBO)</b>			
1. Is the medication prescribed by, or in consultation with, a gastroenterologist?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Does the member have a documented clinical diagnosis of symptomatic (bloating, flatulence, abdominal discomfort, chronic diarrhea) SIBO by one of the following: <ul style="list-style-type: none"> <li>• Glucose or lactulose breath testing</li> <li>• Duodenal culture resulting in colony count <math>\geq 10^3</math> CFU/mL</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Has the member show an inadequate clinical response to at least TWO of the following antibiotic treatment regimens or contraindication to all: <ul style="list-style-type: none"> <li>• Ciprofloxacin</li> <li>• Metronidazole</li> <li>• Amoxicillin-clavulanic acid</li> <li>• Trimethoprim-sulfamethoxazole</li> <li>• Doxycycline or tetracycline</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Has the member shown an Inadequate clinical response to diet modifications (low carbohydrate diet, low fermentable oligosaccharides/disaccharides/monosaccharides/and polyols (FODMAP) diet)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>REAUTHORIZATION</b>			
1. If the request is for reauthorization of therapy for treatment of hepatic encephalopathy, does updated documentation show a positive clinical response from therapy, such as a decrease in fasting serum ammonia levels and mental status?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. If the request is for reauthorization of therapy for IBS-D, is the member responding to treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. If the request is for reauthorization of therapy for traveler's diarrhea, did the member have improved symptoms after 24-48 hours of therapy? <i>Please note that there is a limit of three 14-day treatment courses.</i>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

**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-078

Origination Date: 01/01/2022

Reviewed/Revised Date: 02/17/2023

Next Review Date: 02/17/2024

Current Effective Date: 03/01/2023

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# 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
<b>ASTHMA</b>			
1. Is the prescribing physician an allergist, dermatologist, immunologist, or a pulmonologist?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member shown a positive skin test or in vitro reactivity to a perennial aeroallergen?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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?	<input type="checkbox"/>	<input type="checkbox"/>	
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)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Does documentation include a current Asthma Control Test ≤19?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Are the member's pre-treatment serum IgE levels ≥30 IU/mL and ≤700 IU/mL?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
7. Does documentation include a predicted FEV1 or PEF?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>CHRONIC IDOPATHIC URTICARIA (CIU)</b>			
1. Has the provider performed a medical evaluation that rules out other possible causes of urticaria?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

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

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# 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)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Does the member have exocrine pancreatic insufficiency due to pancreatectomy (including Whipple procedure)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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: <ul style="list-style-type: none"> <li>Fecal elastase-1 &lt;200mcg</li> <li>Fecal elastase-1 &lt;250mcg/g on two distinct tests</li> <li>Peak bicarbonate concentration &lt;80mEq/L (from a direct pancreas function testing with an endoscopic secretin test (one-hour method)</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. If the member has pancreatic insufficiency due to excessive alcohol consumption, has the following been documented: <ul style="list-style-type: none"> <li>Alcohol cessation counseling</li> <li>Offer to enroll in an alcohol abuse program</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

#### REAUTHORIZATION

1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
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2. Has the member's therapy been re-evaluated within the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Has the therapy shown to be effective with an improvement in condition?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Does the member show a continued need for the therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
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: 11/09/2023  
 Next Review Date: 11/09/2024  
 Current Effective Date: 12/01/2023

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# 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
<b>SYSTEMIC LUPUS ERYTHEMATOSUS</b>			
1. Does the member have a confirmed diagnosis of active moderate to severe systemic lupus erythematosus?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Does member meet age requirements for the requested formulation? <ul style="list-style-type: none"> <li>• Member must be ≥5 years for intravenous administration. NOTE: Intravenous administration is non-preferred for members &gt; 80 kg</li> <li>• Member must be ≥18 years for subcutaneous administration.</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	
3. Is the request made by, or in consultation with, a rheumatologist?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Does the member have a Safety of Estrogen in Lupus National Assessment-Systemic Lupus Erythematosus Disease Activity Index (SELENA-SLEDAI) score of ≥ 6?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Does the member have active musculoskeletal or cutaneous disease that is unresponsive to standard therapy with glucocorticoids and/or other immunosuppressive agents?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

6. Is there documentation of corticosteroid-dependent disease (prednisone equivalent dose $\geq 10\text{mg/day}$ ) OR trial and failure of both hydroxychloroquine AND at least 1 immunosuppressant (e.g., azathioprine, methotrexate, mycophenolate)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
7. Has the member been at least 80% compliant for at least 6 months with their baseline therapy (i.e., steroids and/or immunosuppressants)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
8. Will Benlysta® be used concurrently with baseline therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
9. Does the member have documentation of active central nervous system lupus (e.g. generalized seizures, psychosis, stroke, peripheral neuropathies)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
10. Has the member received any other biologics, immunoglobulins, IV cyclophosphamide, or prednisone $>100\text{mg}$ daily within the last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>LUPUS NEPHRITIS</b>			
1. Does the member have a confirmed diagnosis of lupus nephritis?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Is the request made by, or in consultation with, a nephrologist or rheumatologist?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Did the member have a kidney biopsy showing a histological diagnosis of lupus nephritis Class III, IV or V?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Does documentation show a recent $\text{eGFR} \geq 30 \text{ mL/min/1.73m}^2$ ?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Has the member had dialysis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	
6. Is the member currently receiving standard immunosuppressive therapy for systemic lupus erythematosus?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
7. Will Benlysta® be used concurrently with baseline therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
8. Does the member have active central nervous system lupus (e.g. generalized seizures, psychosis, stroke, peripheral neuropathies)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
9. Has the member received any other biologics, immunoglobulins, IV cyclophosphamide, or prednisone $>100\text{mg}$ daily within the last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>REAUTHORIZATION</b>			
<b>SYSTEMIC LUPUS ERYTHEMATOSUS</b>			
1. Is the request for reauthorization of therapy for systemic lupus erythematosus?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does clinical documentation show continued medical necessity, as well as efficacy and tolerability of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Does documentation show continued use of baseline therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>LUPUS NEPHRITIS</b>			
1. Is the request for reauthorization of therapy for lupus nephritis?	<input type="checkbox"/>	<input type="checkbox"/>	
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

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3. Does documentation show continued use of standard therapy during Benlysta® administration?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
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: 01/19/2023  
 Next Review Date: 01/19/2024  
 Current Effective Date: 02/01/2023

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# HEALTH CHOICE

UTAH

## PRIOR AUTHORIZATION REQUEST FORM

### IRON CHELATION THERAPY

deferasirox (Exjade<sup>®</sup>, Jadenu<sup>®</sup>), Jadenu<sup>®</sup>, Ferriprox<sup>®</sup>

**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<sup>®</sup> 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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Is the prescriber a hematologist, or in consultation with one?	<input type="checkbox"/>	<input type="checkbox"/>	

#### DEFERASIROX TABLETS

1. Does the member have an eGFR <40mL/min/1.73 <sup>2</sup> and/or platelet counts <50x10 <sup>9</sup> /L?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Is the request for the indication of chronic iron overload due to blood transfusions? If NO, go to # 6.	<input type="checkbox"/>	<input type="checkbox"/>	
3. Does the member have a history of receiving blood transfusions totaling ≥100mL/kg of packed red blood cells?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Does the member have a liver iron concentration ≥5mg Fe/g dry weight determined by a liver biopsy, T2* MRI, or FerriScan?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Is the request for the indication of chronic iron overload with transfusion-independent thalassemia (non-transfusion-dependent thalassemia) syndromes?	<input type="checkbox"/>	<input type="checkbox"/>	

7. Is the member 10 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>	
8. Does the member have a liver iron concentration $\geq 5\text{mg Fe/g}$ dry weight determined by a liver biopsy, T2* MRI, or FerriScan?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
9. Does the member have a serum ferritin $\geq 300\text{ng/mL}$ on at least 2 consecutive measurements taken at least 1 month apart?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>FERRIPROX®</b>			
1. Does the member have a diagnosis of transfusion-dependent iron overload due to thalassemia syndromes?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Has the member had an adequate trial and failure or contraindication/intolerance to deferasirox or deferoxamine?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Is the member's initial absolute neutrophil count (ANC) $\geq 1.5 \times 10^9/\text{L}$ ?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Does the physician agree to monitor ANC levels while on therapy and to interrupt therapy if neutropenia or signs of infection develop?	<input type="checkbox"/>	<input type="checkbox"/>	
5. Does the member have a transfusion history of $\geq 100\text{mL/kg}$ of packed red blood cells and a serum ferritin level $\geq 1,000\text{ng/mL}$ ?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Does the member have a liver iron concentration $< 7\text{mg Fe/g}$ dry weight determined by a liver biopsy, T2* MRI, FerriScan?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>REAUTHORIZATION</b>			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the member's current liver iron concentration $< 3\text{ mg Fe/g}$ dry weight determined by a liver biopsy, T2* MRI, or FerriScan or ferritin is $\leq 300\text{ng/mL}$ ?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
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: 01/17/2024  
 Next Review Date: 01/17/2025  
 Current Effective Date: 02/01/2024

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# 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:		
<p><i>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.</i></p> <p><b>Product being requested:</b> <input type="checkbox"/> Nuedexta® (dextromethorphan 20mg and quinidine 10mg)</p> <p>Dosing/Frequency: _____</p>		

**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?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the requesting provider a neurologist?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Does the member have a documented diagnosis of pseudobulbar affect (PBA) secondary to at least one of the following: <ul style="list-style-type: none"> <li>• Amyotrophic lateral sclerosis</li> <li>• Multiple sclerosis</li> <li>• Ischemic or hemorrhagic stroke</li> <li>• Traumatic brain injury</li> <li>• Dementia – including Alzheimer’s disease, Vascular, Lewy body, or Frontotemporal Dementia</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Has the underlying condition been stable for at least the past 2 months?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Is there documentation of a baseline Center for Neurologic Studies Liability Score (CNS-LS)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Does the member show clinical symptoms of episodes of sudden uncontrollable and inappropriate laughing or crying?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
7. Is the member’s baseline PBA score $\geq$ 13?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
8. Have the member’s number of PBA episodes per day been documented?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

9. Has the member had a 3-month trial and failure of, or contraindication to, both of the following medication classes: <ul style="list-style-type: none"> <li>• tricyclic antidepressant (TCA)</li> <li>• selective serotonin reuptake inhibitor (SSRI)</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
10. Does documentation show a baseline EKG with any significant abnormalities and/or does the member have a history of QT prolongation syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>REAUTHORIZATION</b>			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member's therapy been re-evaluated within the past 12 weeks with a neurologist?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Has the requesting provider evaluated for a spontaneous improvement of PBA prior to this renewal request?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Does the requesting prescriber agree to re-evaluate EKG if risk factors change during the course of treatment?	<input type="checkbox"/>	<input type="checkbox"/>	
5. Has the member shown a decrease in CNS-LS score?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Has the member shown at least a 30% improvement in the number of PBA episode per day from baseline?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
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: 03/27/2024  
 Next Review Date: 03/27/2025  
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# HEALTH CHOICE

UTAH

## PRIOR AUTHORIZATION REQUEST FORM RUZURGI®

**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:**  Ruzurgi® (amifampridine)

Dosing/Frequency: \_\_\_\_\_

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

Questions	Yes	No	Comments/Notes
1. Is the requesting prescriber a neurologist?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the following diagnosis been ruled out: <ul style="list-style-type: none"> <li>• Myasthenia gravis</li> <li>• Parkinsonism</li> <li>• Peripheral neuropathy</li> <li>• Myopathy</li> <li>• Lumbar spinal stenosis</li> <li>• Psychologic issues</li> <li>• Amyotrophic lateral sclerosis</li> <li>• Guillain-Barre syndrome</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Has the diagnosis of Lambert-Eaton Myasthenic Syndrome been confirmed with the following tests: <ul style="list-style-type: none"> <li>• Presence of antibodies to P/Q type voltage-gates calcium channels in serum</li> <li>• Single fiber electromyography</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Is the member experiencing moderate to severe weakness?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Has the member been screened for malignancy (particularly small cell lung cancer)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. If malignancy is present, does the member meet one of the following: <ul style="list-style-type: none"> <li>• Underlying malignancy has been treat for at least 3 months</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

<ul style="list-style-type: none"> <li>Member has severe LMS symptoms and underlying malignancy is currently being treated</li> <li>The member's malignancy is unable to be treated</li> </ul>			
7. Has the member's medication list been reviewed for any therapies that could aggravate or induce myasthenia (antibiotics, cardiovascular medications, neurological and psychoactive medications, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>REAUTHORIZATION</b>			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member's therapy been re-evaluated within the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Does documentation show a clinically meaningful response to therapy demonstrating improvement of disease and/or updated results of a single fiber electromyography?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Was the member's initial malignancy screening negative? <ul style="list-style-type: none"> <li>If yes, go to question 5.</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation of initial screening and recent screening</b>
5. Has a chest CT scan been done within the past 6 months OR has malignancy been ruled out after at least 2 years of CT scan surveillance?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation of initial screening and recent screening</b>
<b>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.</b>			
Additional information:			
Physician Signature:			

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

Policy PHARM-HCU-084  
Origination Date: 01/01/2022  
Reviewed/Revised Date:  
Next Review Date: 10/13/2022  
Current Effective Date: 01/01/2022

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# 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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Is the request being made by or in consultation with an allergist, ENT specialist, or pulmonologist?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Is the member at 18 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Does documentation show a 3-month trial and failure of or contraindication/intolerance to BOTH of the following intranasal steroids? <ul style="list-style-type: none"> <li>fluticasone propionate 50 mcg/actuation nasal spray</li> <li>mometasone furoate 50 mcg/actuation nasal spray</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. For chronic rhinosinusitis <b>with nasal polyposis (CRSwNP)</b> : Does documentation show diagnosis confirmed by one of the following: <ul style="list-style-type: none"> <li>Anterior rhinoscopy</li> <li>Nasal endoscopy</li> <li>Computed tomography (CT)</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

6. For chronic rhinosinusitis <b>without</b> 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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
7. For chronic rhinosinusitis <b>without</b> nasal polyposis: Does documentation include objective evidence of mucosal inflammation, either by direct visualization or on an imaging study (sinus computed tomography [CT] scan)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>REAUTHORIZATION</b>			
1. Is the requesting for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member's therapy been re-evaluated within the past 6 months?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Has the therapy shown to be effective with an improvement in condition?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Does the member show a continued medical need for the therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
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: 05/22/2024  
 Next Review Date: 05/22/2025  
 Current Effective Date: 06/01/2024

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# 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?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the requesting provider a pulmonologist or in consultation with a pulmonologist?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Has the member been diagnosed with moderate to severe COPD (i.e. COPD GOLD stage II, III, IV)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Does documentation indicate the member is a non-smoker or smoking cessation has been addressed?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
7. Has the member tried at least 2 of the following preferred medications for at least 3 months with an inadequate response: <ul style="list-style-type: none"> <li>• Ipratropium bromide solution for nebulizer</li> <li>• Incruse® Ellipta® (umedclidinium)</li> <li>• Spiriva® Handihaler® (tiotropium)</li> <li>• Spiriva® Respimat® (tiotropium)</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

8. Was the member unable to try two of the preferred medications listed in question 7 due to a medical reason?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>REAUTHORIZATION</b>			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member's therapy been re-evaluated within the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Has the member had a reduction in symptoms?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Has the member had a reduction symptoms and in the number and frequency of exacerbations?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
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: 03/27/2024  
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# 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?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does the member have a documented diagnosis of migraine with or without aura?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Does clinical documentation show either: <ul style="list-style-type: none"> <li>• Member has less than 15 headache days per month?</li> <li>• Member has ≥ 15 headache days per month AND taking a prophylactic agent (e.g. an antidepressant, anticonvulsant, beta-blocker, Botox®, or calcium channel blocker)?</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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, zoliptan)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. For non-preferred medications, has the member had a trial and failure of Ubrelvy®?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

6. Is the member taking a Calcitonin Gene-Related Peptide (CGRP) medication to prevent migraine headaches?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>DIHYDROERGOTAMINE MESYLATE NASAL SPRAY</b>			
1. Has the member had a trial and failure, or intolerance, to dihydroergotamine injection?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>TREXIMET</b>			
1. Has the member tried and found to be intolerant to the inactive ingredients in both naproxen sodium and sumatriptan?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>REAUTHORIZATION</b>			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does documentation show the member has a positive clinical response to therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Is the member taking a Calcitonin Gene-Related Peptide (CGRP) medication to prevent migraine headaches?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
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  
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 Next Review Date: 03/27/2025  
 Current Effective Date: 04/01/2024

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# HEALTH CHOICE

UTAH

## PRIOR AUTHORIZATION REQUEST FORM

### PARKINSON'S AGENTS

Apomorphine hydrochloride injection, Duopa™, Kynmobi™, 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),  Kynmobi™,  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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Is the prescriber a neurologist?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Has the member had an inadequate response to oral levodopa/carbidopa therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

#### APOMORPHINE HYDROCHLORIDE INJECTION

1. Is the request for apomorphine hydrochloride injection?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Will the member be concurrently taking levodopa/carbidopa with apomorphine hydrochloride injection therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Is the member experiencing "off" episodes ("end-of-dose wearing off" and unpredictable "on/off" episodes) associated with advanced Parkinson's disease?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Will the member be taking a 5HT3 antagonist concurrently with apomorphine hydrochloride injection?	<input type="checkbox"/>	<input type="checkbox"/>	

<b>DUOPA™</b>			
1. Is the request for Duopa™?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the member responsive to levodopa with defined “on” periods?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Has the member undergone or has a planned placement of a PEG-J tube?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>KYNMOBI™</b>			
1. Is the request for Kynmobi™?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Will the member be concurrently taking levodopa/carbidopa with Kynmobi™ therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Is the member experiencing “off” episodes (“end-of-dose wearing off” and unpredictable “on/off” episodes) associated with advanced Parkinson’s disease?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Will the member be taking a 5HT3 antagonist concurrently with Kynmobi™?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>NEUPRO®</b>			
1. Is the request for Neupro®?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the member unable to take medications by mouth or is oral therapy clinically inappropriate?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>NOURIANZ™</b>			
1. Is the request for Nourianz™?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Will the member be concurrently taking levodopa/carbidopa with Nourianz™ therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
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)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>ONGENTYS®</b>			
1. Is the request for Ongentys®?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Will the member be concurrently taking levodopa/carbidopa with Ongentys® therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
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)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

RYTARY®			
1. Is the request for Rytary®?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member had at least a 3-month trial and failure or contraindication to generic extended-release carbidopa/levodopa?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
TOLCAPONE			
1. Is the request for tolcapone generic tablets?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member had a 3-month trial and failure or contraindication/intolerance to entacapone or levodopa/carbidopa/entacapone?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Will the member be concurrently taking levodopa/carbidopa with tolcapone therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
ZELAPAR®			
1. Is the request for Zelapar®?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member exhibited deterioration in the quality of their response to levodopa/carbidopa?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Has the member had a trial and failure or contraindication/intolerance to conventional selegiline tablets?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Will the member be concurrently taking levodopa/carbidopa with Zelapar® therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
REAUTHORIZATION			
1. Is the requesting for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the therapy shown to be effective with a positive clinical response?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
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: 03/16/2023  
 Next Review Date: 03/16/2014  
 Current Effective Date: 04/01/2023

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# 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
<b>HYPERTRIGLYCERIDEMIA</b>			
1. Does the member have a diagnosis of severe hypertriglyceridemia with triglyceride (TG) level >500mg/dL?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Does the prescriber attest that the member is on appropriate lipid lowering diet and exercise regimen?	<input type="checkbox"/>	<input type="checkbox"/>	
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>CARDIOVASCULAR RISK REDUCTION WITH MILD HYPERTRIGLYCERIDEMIA</b>			
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)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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: <ul style="list-style-type: none"> <li>• Retinopathy</li> <li>• Microalbuminuria or macroalbuminuria</li> <li>• Renal dysfunction (CrCl &lt;60mL/min)</li> <li>• Hypertension (BP ≥140/90mmHg)</li> <li>• Men ≥55 years of age or women ≥65 years of age</li> <li>• HDL ≤40mg/dL for men or ≤50mg/dL for women</li> <li>• ABI &lt;0.9</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

3. Does the member have a history of NYHA class IV heart failure?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Does the member have a history of severe liver disease?	<input type="checkbox"/>	<input type="checkbox"/>	
5. Does the prescriber attest that the member is on appropriate lipid lowering diet and exercise regimen?	<input type="checkbox"/>	<input type="checkbox"/>	
6. Is the member currently taking a moderate to high intensity statin?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
7. Will the moderate to high intensity statin be continued in combination with Vascepa®?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
8. Does documentation show triglyceride level of 135 to 499mg/dL and LDL level of 40 to 100mg/dL?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>REAUTHORIZATION</b>			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the therapy shown to be effective with an improvement in condition?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Does the member show a continued medical need for the therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
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: 11/09/2023  
 Next Review Date: 11/09/2024  
 Current Effective Date: 12/01/2023

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# HEALTH CHOICE

UTAH

## PRIOR AUTHORIZATION REQUEST FORM

### OFEV<sup>®</sup>, 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<sup>®</sup> (nintedanib)

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: <ul style="list-style-type: none"> <li>• pirfenidone: idiopathic pulmonary fibrosis</li> <li>• Ofev: chronic fibrosing interstitial lung disease with a progressive phenotype, idiopathic pulmonary fibrosis, or systemic sclerosis-associated interstitial lung disease?</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Is the requesting prescriber a pulmonologist or in consultation with a pulmonologist?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Does the member have a forced vital capacity (%FVC) of > 50% predicted?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Does the member have a carbon monoxide diffusing capacity (%DLco) of 30-90% predicted?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Have recent liver function tests been performed?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Is the member's diagnosis confirmed by high-resolution computed tomography (HRCT) scan, a bronchioaveolar lavage (BAL) and/or a surgical lung biopsy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

#### REAUTHORIZATION

1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does the member show a continued medical need and tolerability of the therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Does documentation show current liver enzymes are within normal limits?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

**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: 01/17/2024  
Next Review Date: 01/17/2025  
Current Effective Date: 02/01/2024

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# 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%?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Is the prescriber a hematologist or in consultation with one?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Is the member 18 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Will Cablivi® be started in a hospital setting in combination with plasma exchange?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Will Cablivi® be used in combination with immunosuppressive therapy (e.g. corticosteroids, rituximab)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Have secondary causes of thrombocytopenia been ruled out (e.g. congenital thrombotic thrombocytopenia purpura, hemolytic uremic syndrome, drug-induced thrombocytopenia)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

**REAUTHORIZATION**

1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does documentation show persistent underlying disease with an ADAMTS13 activity <20%?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Has the member experienced >2 recurrences of aTTP during initial therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Has the member demonstrated a positive response to therapy shown by one of the following:	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

<ul style="list-style-type: none"> <li>• Clinically significant increase in platelet count (i.e. platelet count is within the normal range)</li> <li>• Reduction in neurological symptoms</li> <li>• Improvement in organ-damage markers (lactate dehydrogenase, cardiac troponin1 and serum creatinine)</li> </ul>			
<p><b>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.</b></p>			
<p>Additional information:</p>			
<p>Physician Signature:</p>			

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

Policy PHARM-HCU- 094  
 Origination Date: 01/01/2022  
 Reviewed/Revised Date: 05/11/2023  
 Next Review Date: 05/11/2024  
 Current Effective Date: 06/01/2023

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# 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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Has the member demonstrated at least 80% compliance with high intensity statin therapy or contraindication/intolerance to at least four generic statin therapies?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Is the member's fasting LDL-C level > 70mg/dL?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Is the member taking a proprotein convertase substilisin/kexin 9 (PCSK9) inhibitor?	<input type="checkbox"/>	<input type="checkbox"/>	

#### REAUTHORIZATION

1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does documentation show a decrease in baseline LDL-C level of at least 15% from baseline?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

**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: 06/28/2023  
Next Review Date: 06/28/2024  
Current Effective Date: 07/01/2023

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# 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:**  Previmis™ (Ietermovir)

Dosing/Frequency: \_\_\_\_\_

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

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

5. Does the patient have valganciclovir and ganciclovir?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Is the therapy initiated between day 0 and day 7 post-transplant?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
7. Does the member have severe (Child-Pugh C) hepatic impairment?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>INJECTABLE PREVYMIS™</b>			
1. Is the member unable to swallow or has severe dysphagia preventing the use of solid oral medication?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
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: 09/14/2023  
 Next Review Date: 09/14/2024  
 Current Effective Date: 10/01/2023

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# HEALTH | CHOICE

UTAH

## PRIOR AUTHORIZATION REQUEST FORM ADALIMUMAB FOR UVEITIS

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

**Product being requested:**  Hadlima™ (adalimumab-bwwd)  Humira® (adalimumab)

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?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the requesting provider an ophthalmologist or in consultation with one?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Has the member been diagnosed with non-infectious uveitis classified as intermediate, posterior, or panuveitis?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Will Hadlima or Humira be used in combination with any other biologic or small molecule DMARD (Xeljanz, Otezla, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	

**REAUTHORIZATION**

1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
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2. Does documentation show a positive clinical response to treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
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: 09/14/2023  
 Next Review Date: 09/14/2024  
 Current Effective Date: 10/01/2023

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## 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?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does documentation show a diagnosis of cystinosis including a leukocyte cysteine concentration of > 1.5 nmol half-cysteine per milligram of protein?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Does the member have cystine corneal crystals as shown by slit lamp examination?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Does documentation include a baseline Corneal Cystine Crystal Score (CCCS)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

### REAUTHORIZATION

1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
2. Does documentation show a reduction of ≥ 1 unit in the Corneal Cystine Crystal Score (CCCS) after 6 months treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Does documentation show an improvement in vision?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

**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: 01/17/2024  
Next Review Date: 01/17/2025  
Current Effective Date: 02/01/2024

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# HEALTH | CHOICE

UTAH

## PRIOR AUTHORIZATION REQUEST FORM ISTURISA®

**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:		
<p><i>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.</i></p>		
<p><b>Product being requested:</b> <input type="checkbox"/> Isturisa® (osilodrostat)</p>		
<p>Dosing/Frequency: _____</p>		

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

Questions	Yes	No	Comments/Notes
1. Is the prescribing provider an endocrinologist?	<input type="checkbox"/>	<input type="checkbox"/>	
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)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Is the member a candidate for pituitary surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. If the member has had pituitary surgery, was it NOT curative?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Has the member tried and failed, or has a contraindication/intolerance per FDA label to, Signifor® (pasireotide)? Note: Signifor® requires prior authorization	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
7. Has the member tried and failed, or has a contraindication/intolerance per FDA label to ketoconazole or Recorlev® (levoketoconazole)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
8. Does documentation include a baseline electrocardiogram (ECG)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

### REAUTHORIZATION

1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
---	--------------------------	--------------------------	--

2. Does clinical documentation show a continued medical necessity, tolerability and efficacy of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Does clinical documentation show a 24-hour urinary free cortisol below the upper limit of normal?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
Additional information:			

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

Policy: PHARM-HCU-105  
 Origination Date: 01/01/2022  
 Reviewed/Revised Date: 05/11/2023  
 Next Review Date: 05/11/2024  
 Current Effective Date: 06/01/2023

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# 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
<b>EXCESSIVE SOMNOLENCE ASSOCIATED WITH NARCOLEPSY</b>			
1. Is the member 18 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does the member have a baseline ESS score of 15 or higher?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Does the member have a diagnosis of narcolepsy confirmed by polysomnography and MSLT?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Is Sunosi® prescribed by, or in consultation with, a sleep disorder specialist or neurologist?	<input type="checkbox"/>	<input type="checkbox"/>	
5. Has the member tried at least one agent from each of the following categories for at least 3 months each: <ul style="list-style-type: none"> <li>• Central nervous system stimulant (e.g. methylphenidate)</li> <li>• Wakefulness promoting agent (e.g. modafinil)</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Is the member's blood pressure adequately controlled?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
7. Will the member be monitored for psychologic disorders or exacerbations?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>EXCESSIVE SOMNOLENCE ASSOCIATED WITH SLEEP APNEA</b>			
1. Is the member 18 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does the member have a baseline ESS score of 15 or higher?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Does the member have a diagnosis of obstructive sleep apnea confirmed by a sleep disorder specialist with either polysomnography, or OCST?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

4. Is Sunosi® prescribed by, or in consultation with, a sleep disorder specialist or pulmonologist?	<input type="checkbox"/>	<input type="checkbox"/>	
5. Is the member being treated with non-pharmacologic primary treatment modalities (CPAP or similar)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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®?	<input type="checkbox"/>	<input type="checkbox"/>	
7. Will the member continue to use CPAP therapy for at least 6 hours per night with at least 90% compliance during Sunosi® therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
8. Has the member tried modafinil or armodafinil for at least 3 months while using CPAP?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
9. Is the member's blood pressure adequately controlled?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
10. Will the member be monitored for psychologic disorders or exacerbations?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>REAUTHORIZATION</b>			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does documentation show the member had an improvement in ESS score from baseline? <ul style="list-style-type: none"> <li>• At least 5 point improvement for initial renewal</li> <li>• Maintenance of ESS score improvement for ongoing renewals</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
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: 01/19/2023  
 Next Review Date: 01/19/2024  
 Current Effective Date: 02/01/2023

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# 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 7  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
<b>GESTATIONAL DIABETES</b>			
1. Does the member have gestational diabetes or diabetes during pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>DIABETES MELLITUS</b>			
1. Is the member 2 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the prescribing provider an endocrinologist or diabetes specialist?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. For Type 1 Diabetes, if the member is $\geq$ 13 years of age, has the member had at least one year of subcutaneous insulin therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Does the member adhere to a comprehensive diabetes treatment plan and is the member capable of recognizing and responding to the alarms and alerts of the device?	<input type="checkbox"/>	<input type="checkbox"/>	
5. Will the member receive appropriate ongoing counseling and training for CGM use?	<input type="checkbox"/>	<input type="checkbox"/>	
6. Does documentation show diabetes specialist's assessment of ability to train member on appropriate use of continuous glucose monitor?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

7. Does documentation show at least two visits with a diabetes specialist during the six months prior to initiation?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
8. Does documentation show that the member is taking medications that are causing impaired cognitive function or that are affecting the members' ability to appropriately respond to CGM alerts?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
9. Does the member meet one or more of the following criteria while on multiple daily injection insulin or insulin pump therapy? <ul style="list-style-type: none"> <li>Glycosylated hemoglobin levels (HbA1c) greater than 8%.</li> <li>Recent history (within the last six months) of significant, recurring hypoglycemia (less than 60mg/dL or requiring assistance).</li> <li>Wide fluctuations (well above and below set glycemic targets) in blood glucose before and after meal times, despite appropriate adjustment of doses.</li> <li>At least one documented incidence of hyperglycemic hyperosmotic syndrome or diabetic ketoacidosis within the previous six months.</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>REAUTHORIZATION</b>			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does documentation support active and routine use of device?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Does documentation support use of device has resulted in improved diabetic management?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Has the member had at least two visits with a diabetes specialist within the previous 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Have Hemoglobin A1c levels been checked at least every 6 months within the previous year?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Does documentation show that the member is adhering to the treatment plan outlined by a diabetes specialist?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
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: 01/19/2023  
Next Review Date: 01/19/2024  
Current Effective Date: 02/01/2023

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# 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?	<input type="checkbox"/>	<input type="checkbox"/>	
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)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Is the member a candidate for pituitary surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. If the member has had pituitary surgery, was it NOT curative?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

### REAUTHORIZATION

1. Is the requesting for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does updated clinical documentation show stabilization of disease or absence of disease progression?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Does clinical documentation show a 24-hour urinary free cortisol below the upper limit of normal or a decrease by 50% from baseline?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

4. Does the member have an absence of unacceptable drug toxicity?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>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.</b>			
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: 01/19/2023  
 Next Review Date: 01/19/2024  
 Current Effective Date: 02/01/2023

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# 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
1. Does the member have documentation of renal dysfunction with creatinine clearance $\leq$ 50 mL/min for treatment dosing or $<$ 60 mL/min for PrEP dosing?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Does the member have documentation of tenofovir disoproxil fumarate induced renal dysfunction?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Did the member have new onset or worsening of renal dysfunction after starting a tenofovir disoproxil fumarate regimen?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Is the member taking any medications that are considered medically necessary and likely to cause or exacerbate renal dysfunction?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Does the member have an intolerance or contraindication to emtricitabine and tenofovir disoproxil fumarate (generic Truvada®)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Does the member have documentation of osteoporosis confirmed by DEXA Scan OR do serial DEXA scans show osteopenia with progression of bone loss?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
7. For treatment of HIV infection, will Descovy® be used as part of an antiretroviral treatment (ART) regimen?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
8. For PrEP, is the request for an at-risk adult or adolescent ( $\geq$ 35 kg) to reduce the risk of sexually acquired HIV-1 infection?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

9. For PrEP, is the member confirmed to be HIV-negative within 30 days prior to initiation of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>REAUTHORIZATION</b>			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has Descovy shown to be tolerable and effective?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Does the member have a continued medical need for therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. For PrEP, does the member have a documented negative HIV-1 tests every 3 months?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
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: 01/17/2024  
 Next Review Date: 01/17/2025  
 Current Effective Date: 02/01/2024

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# 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?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does the member have a molecularly confirmed diagnosis of a long-chain fatty acid oxidation disorder based on 2 of the following: <ul style="list-style-type: none"> <li>• Disease-specific acylcarnitine elevations on a newborn blood spot or in plasma</li> <li>• Enzyme activity assay (in cultured fibroblasts or lymphocytes) below the lower limit of normal</li> <li>• Genetic testing demonstrating pathogenic mutations in a gene associated long-chain fatty acid oxidation disorders</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Is the member receiving disease related dietary management?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

**REAUTHORIZATION**

1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does updated clinical documentation show disease progression or toxicity to therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

**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: 01/19/2023  
Next Review Date: 01/19/2024  
Current Effective Date: 02/01/2023

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# HEALTH CHOICE

UTAH

## PRIOR AUTHORIZATION REQUEST FORM

### NERLYNX®

**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:**  Nerlynx® (neratinib)

Dosing/Frequency: \_\_\_\_\_

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

Questions	Yes	No	Comments/Notes
1. Will Nerlynx be used in combination with capecitabine?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does the member has a confirmed diagnosis of HER-2 positive recurrent or stage IV metastatic breast cancer?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Has the member received ≥ 2 anti-HER2 based regimens in the metastatic setting?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

#### REAUTHORIZATION

1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does updated clinical documentation show no progress or unacceptable toxicity?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

**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-113  
Origination Date: 01/01/2022  
Reviewed/Revised Date: 02/17/2023  
Next Review Date: 02/17/2024  
Current Effective Date: 03/01/2023

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# HEALTH | CHOICE

UTAH

## PRIOR AUTHORIZATION REQUEST FORM

### EVRYSDI™

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**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.**

**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?	<input type="checkbox"/>	<input type="checkbox"/>	
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: <ul style="list-style-type: none"> <li>• 5q SMA homozygous gene deletion</li> <li>• 5q SMA homozygous gene mutation</li> <li>• Compound heterozygote mutation (e.g. deletion of SMN1 exon 7 and mutation of SMN1)?</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
3. Does documentation show the member has a diagnosis of SMA types 1, 2, or 3?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Is the member ≤ 25 years of age?	<input type="checkbox"/>	<input type="checkbox"/>	
5. Is the member dependent on any of the following: <ul style="list-style-type: none"> <li>• Invasive ventilation or tracheostomy</li> <li>• Non-invasive ventilation support beyond naps and nighttime sleep?</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	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?	<input type="checkbox"/>	<input type="checkbox"/>	
7. Does the member have hepatic dysfunction?	<input type="checkbox"/>	<input type="checkbox"/>	
8. Has the member received Zolgensma®?	<input type="checkbox"/>	<input type="checkbox"/>	

9. Is the member currently taking Spinraza® or will Spinraza® be started in addition to Evrysdi™?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>REAUTHORIZATION</b>			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member responded to initial therapy as shown by maintenance, improvement, or decreased decline in motor function?	<input type="checkbox"/>	<input type="checkbox"/>	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: 01/17/2024  
 Next Review Date: 01/17/2025  
 Current Effective Date: 02/01/2024

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# 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:		
<p><i>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.</i></p>		
<p><b>Product being requested:</b> <input type="checkbox"/> Lupkynis™ (voclosporin)</p>		
<p>Dosing/Frequency: _____</p>		

#### 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?	<input type="checkbox"/>	<input type="checkbox"/>	
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Does documentation include a kidney biopsy showing a histological diagnosis of lupus nephritis Class III, IV, or V?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Is the member's recent eGFR $\geq 45$ mL/min/1.73m <sup>2</sup> ?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Does the member have a history of kidney transplant?	<input type="checkbox"/>	<input type="checkbox"/>	
6. Has the member had a trial and failure, or contraindication/intolerance, to Benlysta (belimumab)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
7. Does documentation show Lupkynis™ will be used concurrently with mycophenolate or azathioprine AND a systemic steroid?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
8. For women of childbearing potential, does the member have a negative serum pregnancy test at screening and negative urine pregnancy test at baseline?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

#### REAUTHORIZATION

1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
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2. Has the member been compliant with background immunosuppressive therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
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

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# 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:		
<p><i>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.</i></p> <p><b>Product being requested:</b>) <input type="checkbox"/> Cabenuva® (Cabotegravir/rilpivirine), <input type="checkbox"/> Vocabria® (cabotegravir)</p> <p>Dosing/Frequency: _____</p>		

**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?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does documentation show the member is HIV (human immunodeficiency) positive?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Does documentation show a current HIV viral load <50 copies/mL?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Has the member been stable on an antiretroviral regimen for at least the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Does documentation show a history of treatment failure?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Is there known or suspected virologic resistance to cabotegravir or rilpivirine?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
7. Does documentation show that the member has the ability and willingness to visit the clinic to receive injection?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
8. Does the member have an active hepatitis B virus (HBV) infection?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
9. Has the member tried and failed all appropriate preferred HIV regimens?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
10. Does documentation show the member has one of the following: <ul style="list-style-type: none"> <li>• Severe gastrointestinal issues that likely limits absorption or tolerance of oral medications</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

<ul style="list-style-type: none"> <li>Social circumstances or mental capacity issues that make compliance with an oral antiretroviral regimen unlikely?</li> </ul>			
11. Is the member pregnant or planning to become pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>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.</b>			
Additional information:			
Physician Signature:			

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

Policy PHARM-HCU-119  
Origination Date: 01/01/2022  
Reviewed/Revised Date: 05/11/2023  
Next Review Date: 05/11/2024  
Current Effective Date: 06/01/2023

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# 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:**  Livtency® (maribavir)

Dosing/Frequency: \_\_\_\_\_

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

Questions	Yes	No	Comments/Notes
<b>CYTOMEGALOVIRUS (CMV) WITH POST-TRANSPLANT CMV INFECTION/DISEASE</b>			
1. Is the member 12 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does the member weigh at least 35 kg?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Is the requesting provider an infectious disease specialist, hematologist, oncologist, or transplant specialist?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Is the member a recipient of hematopoietic stem cell or solid organ transplant?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Has the member tried and failed, or have a contraindication, intolerance, or resistance to all of the following medications: <ul style="list-style-type: none"> <li>• Ganciclovir or valganciclovir, foscarnet, and cidofovir</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Is the member on any other CMV antivirals?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
7. Is the member pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	

**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: 01/27/2022  
Next Review Date: 01/27/2023  
Current Effective Date: 02/01/2022

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# 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
<b>NEUROTROPHIC KERATITIS</b>			
1. Is the member 18 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the requesting provider an ophthalmologist?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Does the member have a diagnosis of stage 2 or 3 neurotrophic keratitis in one or both eyes?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Has corneal sensation been measured and shows reduction?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Does the member have a best corrected distance visual acuity (BCDVA) score of $\leq 75$ Early Treatment Diabetic Retinopathy Study (ETDRS) letters, ( $\geq +0.2$ LogMAR, $\leq 20/32$ Snellen or $\leq 0.625$ decimal fraction) in the affected eye?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
7. Has the member received Oxervate in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

**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: 01/19/2023  
Next Review Date: 01/19/2024  
Current Effective Date: 02/01/2023

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# 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
<b>HETEROZYGOUS FAMILIAL HYPERCHOLESTEROLEMIA</b>			
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Does the member have a diagnosis of heterozygous familial hypercholesterolemia (HeFH) confirmed by either of the following: <ul style="list-style-type: none"> <li>• Untreated LDL-C level <math>\geq</math> 190 mg/dL in adults</li> <li>• Untreated LDL-C level <math>\geq</math> 160 mg/dL and tendon xanthoma in members &lt; 20 years of age</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Does the member have one of the following: <ul style="list-style-type: none"> <li>• Genetic confirmation testing that demonstrates LDL-R mutation, LDLRAP1 mutation, familial defective apo B100, or a PCSK9 mutation</li> <li>• A diagnosis confirmed by the World Health Organization/Dutch Lipid Network Criteria resulting in a score &gt; 8 points</li> <li>• A diagnosis meeting the threshold for definite or possible/probable familial hypercholesterolemia per Simon Broome Criteria</li> <li>• Arcus senilis if &lt; 45 years of age</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

<ul style="list-style-type: none"> <li>• Have a first degree relative with similarly elevated LDL-C, early ASCVD (&lt;55 years of age for men, &lt;65 years of age for women), tendon xanthoma, or corneal arcus</li> </ul>			
4. Does clinical documentation show a recent baseline low-density lipoprotein cholesterol (LDL-C) level?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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 $\geq$ 100 mg/dL?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Does the member show LDL-C is unresponsive to standard PCSK9 therapy for an adequate duration (i.e., 3-6 months)? <ul style="list-style-type: none"> <li>• Documentation must show trial and failure to Repatha®</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
7. Will Leqvio® be used concurrently with a maximally tolerated statin therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
8. If the member has a contraindication to all statins, does documentation show one of the following: <ul style="list-style-type: none"> <li>• Active liver disease</li> <li>• Diagnosis or history of rhabdomyolysis</li> <li>• Pregnant or nursing mothers</li> <li>• Allergic reaction with rash and/or anaphylactic symptoms</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
9. If the member has a hypersensitivity to statins, does documentation show all of the following: <ul style="list-style-type: none"> <li>• Inability to tolerate at least 2 different statins at the lowest starting dose</li> <li>• Intolerance associated with confirmed, intolerable statin-related adverse effects or significant biomarker abnormalities</li> <li>• Symptom and/or biomarker resolution upon discontinuation</li> <li>• Attestation that adverse effects are not attributable to drug-drug interactions or recognized conditions that can cause similar changes (e.g., hypothyroidism)</li> <li>• 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</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
10. Is the member at least 80% compliant for at least 6 months with their baseline therapy (i.e., statins, ezetimibe)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
11. Has the addressed lifestyle modifications (i.e., a heart healthy diet, the importance of exercise, and smoking cessation) been completed?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
12. Will the member be concurrently receiving any of the following medications in combination with Leqvio®: <ul style="list-style-type: none"> <li>• Praluent® (alirocumab)</li> <li>• Repatha® (evolocumab)</li> <li>• Nexletol® (bempedoic acid)</li> <li>• Nexlizet® (bempedoic acid and ezetimibe)</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>HIGH RISK OF ATHEROSCLEROTIC CARDIOVASCULAR DISEASE (ASCVD)</b>			
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

<p>2. Does the member have a diagnosis of high risk atherosclerotic cardiovascular disease (ASCVD) with one of the following:</p> <ul style="list-style-type: none"> <li>• History of myocardial infarction</li> <li>• Non-hemorrhagic stroke</li> <li>• Symptomatic peripheral artery disease</li> <li>• Acute coronary syndromes</li> <li>• Coronary artery disease</li> <li>• Stable or unstable angina</li> <li>• Coronary or other arterial revascularization</li> <li>• Transient ischemic attack</li> <li>• Diabetes</li> <li>• 10-year Framingham risk score of 20% or higher</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<p><b>Please provide documentation</b></p>
<p>3. Does clinical documentation show a recent baseline low-density lipoprotein cholesterol (LDL-C) level?</p>	<input type="checkbox"/>	<input type="checkbox"/>	<p><b>Please provide documentation</b></p>
<p>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 <math>\geq 70</math> mg/dL?</p>	<input type="checkbox"/>	<input type="checkbox"/>	<p><b>Please provide documentation</b></p>
<p>5. Does the member show LDL-C is unresponsive to standard PCSK9 therapy for an adequate duration (i.e., 3-6 months)?</p> <ul style="list-style-type: none"> <li>• Documentation must show trial and failure to Repatha®</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<p><b>Please provide documentation</b></p>
<p>6. Will Leqvio® be used concurrently with a maximally tolerated statin therapy?</p>	<input type="checkbox"/>	<input type="checkbox"/>	<p><b>Please provide documentation</b></p>
<p>7. If the member has a contraindication to all statins, does documentation show one of the following:</p> <ul style="list-style-type: none"> <li>• Active liver disease</li> <li>• Diagnosis or history of rhabdomyolysis</li> <li>• Pregnant or nursing mothers</li> <li>• Allergic reaction with rash and/or anaphylactic symptoms</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<p><b>Please provide documentation</b></p>
<p>8. If the member has a hypersensitivity to statins, does documentation show all of the following:</p> <ul style="list-style-type: none"> <li>• Inability to tolerate at least 2 different statins at the lowest starting dose</li> <li>• Intolerance associated with confirmed, intolerable statin-related adverse effects or significant biomarker abnormalities</li> <li>• Symptom and/or biomarker resolution upon discontinuation</li> <li>• Attestation that adverse effects are not attributable to drug-drug interactions or recognized conditions that can cause similar changes (e.g., hypothyroidism)</li> <li>• 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 colestevlam is used</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<p><b>Please provide documentation</b></p>
<p>9. Is the member at least 80% compliant for at least 6 months with their baseline therapy (i.e., statins, ezetimibe)?</p>	<input type="checkbox"/>	<input type="checkbox"/>	<p><b>Please provide documentation</b></p>
<p>10. Has the provider addressed lifestyle modifications (i.e., a heart healthy diet, the importance of exercise, and smoking cessation) been completed?</p>	<input type="checkbox"/>	<input type="checkbox"/>	<p><b>Please provide documentation</b></p>

11. Will the member be concurrently receiving any of the following medications in combination with Leqvio®: <ul style="list-style-type: none"> <li>• Praluent® (alirocumab)</li> <li>• Repatha® (evolocumab)</li> <li>• Nexletol® (bempedoic acid),</li> <li>• Nexlizet® (bempedoic acid and ezetimibe)</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>REAUTHORIZATION</b>			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does documentation indicate an adequate reduction in LDL-C defined by one of the following: <ul style="list-style-type: none"> <li>• ≥ 40% reduction in LDL-C level compared to baseline or reduction to LDL goal in members with a diagnosis of ASCVD</li> <li>• Reduction in LDL-C level compared to baseline in members with a diagnosis of HeFH</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Is member adherent to concurrent statin therapy at the maximum tolerated dose?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Is member adherent to lifestyle modifications (i.e., a heart healthy diet, the importance of exercise, and smoking cessation)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
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: 09/14/2023  
 Next Review Date: 09/14/2024  
 Current Effective Date: 10/01/2023

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# 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
<b>CHRONIC GRAFT-VERSUS-HOST DISEASE</b>			
1. Does the member have a diagnosis of chronic graft-versus-host disease?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Does documentation show trial and failure of at least two systemic treatments (i.e., methylprednisolone, Imbruvica (ibrutinib), cyclosporine, tacrolimus, sirolimus, mycophenolate mofetil, imatinib)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>REAUTHORIZATION</b>			
1. Is the requesting for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does clinical documentation show continued medical necessity and evidence of a positive clinical response to therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

**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: 02/17/2023  
Next Review Date: 02/17/2024  
Current Effective Date: 03/01/2023

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# HEALTH | CHOICE

UTAH

## PRIOR AUTHORIZATION REQUEST FORM TAVNEOS®

**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:**  Tavneos® (avacopan)

Dosing/Frequency: \_\_\_\_\_

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

Questions	Yes	No	Comments/Notes
<b>SEVERE ANTINEUTROPHIL CYTOPLASMIC AUTOANTIBODY (ANCA)-ASSOCIATED VASCULITIS (AAV)</b>			
1. Is the member ≥ 18 years of age?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Is the request made by, or in consultation with, a rheumatologist?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Does the member have a diagnosis of either of the following: <ul style="list-style-type: none"> <li>• Active antineutrophil cytoplasmic autoantibody (ANCA)-associated vasculitis (AAV) due to granulomatosis with polyangiitis (GPA); or</li> <li>• Microscopic polyangiitis (MPA)</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Does documentation show positive anti-proteinase 3 (PR3) or anti-myeloperoxidase (MPO) ANCA-associated vasculitis?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Does the member have a current eGFR ≥ 15 mL/min/1.73m <sup>2</sup> ?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Does the member currently require dialysis or have a kidney transplant, and has received plasma exchange in the past 12 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
7. Does the member have a baseline Birmingham Vasculitis Activity Score (BVAS; version 3) with either of the following: <ul style="list-style-type: none"> <li>• At least one or more major items</li> <li>• At least three or more non-major items</li> <li>• At least two renal items of hematuria and proteinuria</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

8. Has the member had at least a 3-month trial and failure of glucocorticoid therapy at the maximally indicated doses, unless contraindicated or a clinically significant intolerance is experienced?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
9. Does documentation show concurrent therapy with cyclophosphamide or rituximab?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
10. Does documentation show baseline Hepatitis B (HBV) prior to initiating therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>REAUTHORIZATION</b>			
1. Is the requesting for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member shown a $\geq 50\%$ reduction of BVAS score from baseline?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Does documentation show continued liver function monitoring performed by the provider?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
Additional information:			
Physician Signature:			

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

Policy: PHARM-HCU-132  
 Origination Date: 02/02/2022  
 Reviewed/Revised Date: 03/16/2023  
 Next Review Date: 03/16/2024  
 Current Effective Date: 04/01/2023

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# HEALTH CHOICE

UTAH

## PRIOR AUTHORIZATION REQUEST FORM

### LIVMARLI™

**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:**  Livmarli™ (maralixibat)

Dosing/Frequency: \_\_\_\_\_

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

Questions	Yes	No	Comments/Notes
<b>MODERATE TO SEVERE CHOLESTATIC PRURITIS</b>			
1. Is the request prescribed by a hepatologist, gastroenterologist, or provider specialized in Alagille syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Is the member ≥ 12 months and ≤ 18 years of age at therapy initiation?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Does the member have a clinical diagnosis of Alagille Syndrome confirmed by genetic testing with one of the following: <ul style="list-style-type: none"> <li>• JAG1: Deletion or mutation</li> <li>• NOTCH2: Deletion or mutation</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Does the member have at least one of the following markers for cholestasis: <ul style="list-style-type: none"> <li>• Gamma-glutamyl transferase &gt; 3 times above the upper limit of normal reference range</li> <li>• Total serum bile acid &gt; 3 times above the upper limit of normal reference range</li> <li>• Conjugated bilirubin &gt; 1 mg/dL</li> <li>• Unexplainable fat-soluble vitamin deficiency</li> <li>• Intractable pruritus due to liver disease</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Does the member have a documented daily score > 2 in the Itch Reported Outcome (ItchRO™) assessment for two consecutive weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

6. Has the member trialed all of the following medications with inappropriate clinical response, unless contraindicated: <ul style="list-style-type: none"> <li>• Rifampin</li> <li>• Cholestyramine</li> <li>• Ursodeoxycholic acid</li> <li>• Antihistamines</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
7. Does the member have any of the following conditions: <ul style="list-style-type: none"> <li>• Concomitant liver disease</li> <li>• History of decompensated cirrhosis (e.g., ascites, encephalopathy, variceal hemorrhage)</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>REAUTHORIZATION</b>			
1. Is the requesting for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member responded to initial therapy with a positive clinical response demonstrated by a decrease in pruritis severity or decrease in serum bile acid?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Has the member experienced a hepatic decompensation event (e.g., ascites, encephalopathy, variceal hemorrhage)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Does the member have a concomitant liver disease?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
Additional information:			
Physician Signature:			

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

Policy: PHARM- HCU-133  
 Origination Date: 03/09/2022  
 Reviewed/Revised Date: 03/16/2023  
 Next Review Date: 03/16/2024  
 Current Effective Date: 04/01/2023

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# 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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Is the member confirmed to be HIV-negative within 30 days prior to initiation of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Does the member have an intolerance or contraindication to emtricitabine and tenofovir disoproxil fumarate (generic Truvada®)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Does the member have documentation of tenofovir disoproxil fumarate induced renal dysfunction?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Did the member have new onset or worsening of renal dysfunction after starting a tenofovir disoproxil fumarate regimen?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Is the member taking any medications that are considered medically necessary and likely to cause or exacerbate renal dysfunction?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
7. Does the member have documentation of renal dysfunction with creatinine clearance <60 mL/min?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
8. Does the member have documentation of osteoporosis confirmed by DEXA Scan OR do serial DEXA scans show osteopenia with progression of bone loss?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

#### REAUTHORIZATION

1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
---	--------------------------	--------------------------	--

2. Has Aprelude shown to be tolerable and effective?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Does the member have a continued medical need for therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Does the member have a documented negative HIV-1 test every 3 months?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
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: 05/11/2023  
 Next Review Date: 05/11/2024  
 Current Effective Date: 06/01/2023

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# HEALTH CHOICE

UTAH

## PRIOR AUTHORIZATION REQUEST FORM

### Brand Name Atopic Dermatitis Agents

Adbry™, Cibinqo™, Dupixent®, Eucrisa®, Opzelura™, Rinvoq®

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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™,  Cibinqo™,  Dupixent® (dupilumab),  Eucrisa®,  Opzelura™,  Rinvoq®

Dosing/Frequency: \_\_\_\_\_

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

Questions	Yes	No	Comments/Notes
<b>EUCRISA</b>			
1. Does the member have a diagnosis of mild to moderate atopic dermatitis?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Does documentation show that the member has had an adequate trial and failure of at least one topical corticosteroid?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Does documentation show that the member has had an adequate trial and failure of topical tacrolimus or topical pimecrolimus?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>OPZELURA</b>			
1. Is the request made by a provider specializing in dermatology, allergy, or immunology?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does documentation show a confirmed diagnosis of mild to moderate atopic dermatitis in a non-immune compromised individual who is not adequately controlled with topical prescription therapies or when these therapies are not advisable?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Is the affected area less than 20% of body surface area?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Does the quantity requested exceed one tube per 30 days?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Has the member had an adequate trial with the following: <ul style="list-style-type: none"> <li>• a topical calcineurin inhibitor, such as pimecrolimus or tacrolimus,</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

<ul style="list-style-type: none"> <li>two medium to high potency corticosteroids (e.g., triamcinolone acetonide 0.1%, mometasone furoate 0.1%, betamethasone dipropionate 0.05%, desoximetasone 0.05%), and</li> <li>phototherapy?</li> </ul>			
<b>SYSTEMIC AGENTS</b>			
1. Is the request made by a provider specializing in dermatology, allergy, or immunology?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member had an adequate trial with at least two moderate to very high potency prescription corticosteroids?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. 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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Has the member tried phototherapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Has the member had a trial of at least one of the following in the past 6 months: <ul style="list-style-type: none"> <li>oral corticosteroid</li> <li>intramuscular steroid</li> <li>cyclosporine</li> <li>azathioprine</li> <li>methotrexate</li> <li>mycophenolate</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>CIBINQO</b>			
1. Has the member had a 3-month trial and failure of Dupixent and Adbry, unless contraindicated?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Does Clinical documentation show that Tb and Hepatitis Screening have been done?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>RINVOQ</b>			
1. Has the member had a 3-month trial and failure of Adbry, Cibinqo and Dupixent, unless contraindicated?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Does Clinical documentation show that Tb and Hepatitis Screening have been done?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>REAUTHORIZATION</b>			
1. Is the request for reauthorization of atopic dermatitis therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is there evidence of positive clinical response?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
Additional information:			

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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: 01/19/2023  
Next Review Date: 01/19/2024  
Current Effective Date: 02/01/2023

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# HEALTH | CHOICE

UTAH

## PRIOR AUTHORIZATION REQUEST FORM

### Non-Radiographic Axial Spondyloarthritis (nrx-SpA)

Avsola<sup>®</sup>, Cimzia<sup>®</sup>, Cosentyx<sup>®</sup>, Inflectra<sup>®</sup>, infliximab, Remicade<sup>®</sup>, Renflexis<sup>®</sup>, Taltz<sup>®</sup>

**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<sup>®</sup> (infliximab-axxq), Inflectra<sup>®</sup> (infliximab-dyyb), infliximab, Remicade (infliximab), Renflexis<sup>®</sup> (infliximab-abda)
- 2. 2<sup>nd</sup> line preferred agents with single step; after trial and failure of 1 preferred first line agent:**
  - A. Cimzia<sup>®</sup> (certolizumab), Taltz<sup>®</sup> (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<sup>®</sup> (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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Is the requesting provider a rheumatologist or in consultation with one?	<input type="checkbox"/>	<input type="checkbox"/>	
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Has the provider performed tuberculosis (TB) screening prior to therapy initiation?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. For tumor necrosis factor inhibitors (TNFIs), has the provider performed Hepatitis B screening prior to therapy initiation?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does updated documentation show that the member has a continued medical need?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Has the provider performed continued tuberculosis screening during therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Has the provider performed continued Hepatitis B monitoring in HBV carriers?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
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

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# 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)

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

Questions	Yes	No	Comments/Notes
<b>EOSINOPHILIC GRANULOMATOSIS WITH POLYANGIITIS (EGPA)</b>			
1. Is the request made by, or in consultation with, a pulmonologist, rheumatologist, allergist, or immunologist?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does the member have a past medical history or presence of asthma?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Does documentation show blood eosinophil level of $\geq 10\%$ or an absolute count $> 1000 \text{ cells/mm}^3$ ?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Does the member have a confirmed diagnosis of EGPA with at least 2 of the following: <ul style="list-style-type: none"> <li>• Neuropathy</li> <li>• Pulmonary infiltrates</li> <li>• Sinonasal abnormality</li> <li>• Cardiomyopathy</li> <li>• Glomerulonephritis</li> <li>• Alveolar hemorrhage</li> <li>• Palpable purpura</li> <li>• Antineutrophil cytoplasmic antibody (ANCA) positivity</li> <li>• Histopathologic evidence of eosinophilic vasculitis, perivascular eosinophilic infiltration or eosinophil rich granulomatous inflammation</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

5. Has the member been on a stable corticosteroid dose for at least 4 weeks prior to Nucala® therapy initiation?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Has the member had a trial and failure of at least one of the following immunosuppressants used for maintenance therapy: azathioprine, methotrexate, or leflunomide?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
7. Does documentation show objective baseline severity (e.g. nighttime awakenings, daytime symptoms, FEV1, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>HYPEREOSINOPHILIC SYNDROME</b>			
1. Has the member had a diagnosis of hypereosinophilic syndrome for at least 6 months without an identifiable non-hematologic secondary cause?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Does documentation show the member is negative for platelet-derived growth factor receptor alpha ( <i>PDGFRA</i> ) and <i>FIP1L1</i> ?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Have other causes of elevated eosinophils and/or organ damage been ruled out?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>NUCALA FOR ASTHMA</b>			
1. Does the member have a confirmed diagnosis of eosinophilic asthma?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member tried and failed or have a contraindication or intolerance to the preferred product Fasentra® (benralizumab)?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Does documentation show the member's baseline eosinophil count?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Is the request made by an asthma specialist, allergist, immunologist, or pulmonologist?	<input type="checkbox"/>	<input type="checkbox"/>	
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Does the member have poor asthma control, defined as two or more acute exacerbations in the past 12 months requiring additional medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
7. Does documentation show the member's forced expiratory volume (FEV1) is < 80%?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
8. Are underlying conditions or triggers for asthma or pulmonary disease maximally managed?	<input type="checkbox"/>	<input type="checkbox"/>	
9. Is the member an active smoker? If yes, does documentation show that smoking cessation has been addressed?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>REAUTHORIZATION</b>			
<b>For EGPA:</b>			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does updated documentation show that the member has experienced a positive clinical response of at least one of the following:	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

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<ul style="list-style-type: none"> <li>• reduction in the frequency and/or severity of relapses</li> <li>• reduction or discontinuation of doses of corticosteroids and/or immunosuppressants</li> <li>• disease remission</li> <li>• reduction in severity or frequency of EGPA-related symptoms</li> </ul>			
<b>For Hypereosinophilic Syndrome</b>			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does documentation show a positive response to therapy evidenced by a reduction in frequency of HES flares?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>For Asthma</b>			
Is the request for reauthorization?	<input type="checkbox"/>	<input type="checkbox"/>	
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.?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
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: 01/19/2023  
 Next Review Date: 01/19/2024  
 Current Effective Date: 02/01/2023

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# 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: <ul style="list-style-type: none"> <li>• 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</li> <li>• Clinical documentation shows definitive diagnosis of tuberous sclerosis complex</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Does the member have three or more facial angiofibromas that are at least 2 mm in diameter with redness in each?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Is the member candidate for laser therapy or surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

#### REAUTHORIZATION

1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does updated documentation show that the member has a continued medical need?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

**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: 01/17/2024  
Next Review Date: 01/17/2025  
Current Effective Date: 02/01/2024

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# 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
<b>DUPIXENT, NUCALA</b>			
1. Does the member have a diagnosis of chronic rhinosinusitis with nasal polyposis confirmed by anterior rhinoscopy, nasal endoscopy, or computed tomography (CT)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Is the request made by, or in consultation with, an allergist, pulmonologist or ENT specialist?	<input type="checkbox"/>	<input type="checkbox"/>	
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Has the member tried and failed at least two weeks of systemic corticosteroid therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Has the member tried and failed at least two weeks of doxycycline or macrolide antibiotics?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Will the requested therapy be used in combination with an intranasal corticosteroid?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>XOLAIR</b>			
1. Does the documentation include the current body weight and baseline serum IgE?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

REAUTHORIZATION			
1. Is the request for reauthorization of chronic rhinosinusitis therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member experienced a reduction in their nasal congestion and nasal polyp size?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>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.</b>			
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: 01/19/2023  
 Next Review Date: 01/19/2024  
 Current Effective Date: 02/01/2023

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# 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 (roflumilast)™

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 dermatologist?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does the member have a diagnosis of psoriasis?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Does the member take any of the following medications? <ul style="list-style-type: none"> <li>• Biologic DMARDs [e.g., Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab), Cosentyx (secukinumab), Stelara (ustedkinumab), Orencia (abatacept)]; OR</li> <li>• Janus Kinase Inhibitors [e.g., Xeljanz (tofacitinib), Oluminat (baricitinib), Rinvoq (upacitinib)]; OR</li> <li>• Phosphodiesterase 4 (PDE4) inhibitors [e.g., Otezla (apremilast)]</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Is the affected area less than 20% of body surface area?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Does documentation show failure or contraindication to topical calcineurin inhibitor, such as pimecrolimus or tacrolimus?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Does documentation show failure or contraindication to ALL of the following? <ul style="list-style-type: none"> <li>• two medium to high potency corticosteroids (e.g., triamcinolone acetone 0.1%, mometasone furoate 0.1%,</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

betamethasone dipropionate 0.05%, desoximetasone 0.05%); AND			
<ul style="list-style-type: none"> <li>a topical calcineurin inhibitor such as pimecrolimus or tacrolimus; AND</li> <li>phototherapy</li> </ul>			
<b>REAUTHORIZATION</b>			
1. Is the requesting for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does the member show a continued medical need for the therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Does the therapy been tolerable and effective?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
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: 04/19/2023  
 Next Review Date: 04/19/2024  
 Current Effective Date: 05/01/2023

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# HEALTH CHOICE

UTAH

## PRIOR AUTHORIZATION REQUEST FORM

### MOUNJARO and GLP-1s

(Bydureon®, Ozempic®, Rybelsus®, Trulicity®, and Victoza®)

**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

Preferred:  Bydureon® (exenatide),  Ozempic® (semaglutide),  Rybelsus®(semaglutide),  Trulicity®(dulaglutide), and  Victoza®(liraglutide)

Non-Preferred:  Mounjaro®(tirzapatide)

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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Has the member tried and failed generic metformin or a generic metformin-containing combination for at least 3 months?	<input type="checkbox"/>	<input type="checkbox"/>	

#### MOUNJARO®

1. Has the member tried and failed a preferred GLP-1 without desired effect?	<input type="checkbox"/>	<input type="checkbox"/>	
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#### REAUTHORIZATION

1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does the member show a continued medical need for the therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Has the therapy been tolerable and effective?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

**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: 01/19/2023  
Next Review Date: 01/19/2024  
Current Effective Date: 02/01/2023

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## 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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Is the requesting provider an HIV or infectious disease specialist, or in consultation with one?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Is the member is currently failing an antiretroviral drug regimen in the treatment of HIV-1?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Is the member is adherent to antiretroviral regimen(s)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

<ul style="list-style-type: none"> <li>• Nucleoside reverse transcriptase inhibitors (NRTI) (e.g, abacavir, didanosine, emtricitabine, lamivudine, stavudine, tenofovir disoproxil fumarate, tenofovir alafenamide, zidovudine)</li> <li>• Non-nucleoside reverse transcriptase inhibitors (NNRTI) (e.g., delaviridine, efavirenz, etravirine, nevirapine, nevirapine XR, rilpivirine)</li> <li>• Protease inhibitors (PI) (e.g., atazanavir, darunavir, fosamprenavir, indinavir, nelfinavir, ritonavir, saquinavir, tipranavir)</li> <li>• Integrase inhibitors (e.g., raltegravir, dolutegravir, elvitegravir)</li> <li>• CCR5-antagonists (e.g., Selzentry® (maraviroc))</li> </ul>			
6. Will the requested drug be used in combination with optimized background antiretroviral regimen(s)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
7. Does the member have a plasma HIV RNA viral load $\geq$ 400 copies/mL?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
8. Does the member have a documented CD4 count within the past 30 days?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
9. For Rukobia™, does clinical documentation show trial and failure of Sunlenca® or medical necessity for oral administration?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
10. For Trogarzo®, does clinical documentation show trial and failure of Sunlenca® and Rukobia™?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>REAUTHORIZATION</b>			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Is the member adherent to the HIV regimen and optimized background antiretroviral regimen(s)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
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: 03/16/2023  
 Next Review Date: 03/16/2014  
 Current Effective Date: 04/01/2023

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# 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
<b>GENDER DYSPHORIA IN CHILDREN/ADOLESCENTS</b>			
1. Is the member <18 years of age?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Was the member diagnosed with gender dysphoria prior to January 28, 2023?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Does documentation demonstrate that the provider has been treating the patient for gender dysphoria for at least 6 months?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Has a health evaluation been completed by a medical health professional that includes the following: <ul style="list-style-type: none"> <li>• the medical health professional is different from the hormonal transgender treatment provider</li> <li>• has a transgender treatment certification</li> <li>• documentation of history of at least 3 therapy sessions with the member</li> <li>• documentation of all mental health diagnoses and any significant life events that may be contributing to the member's diagnoses</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Has the member experienced persistent, well documented gender dysphoria/gender incongruence including a marked	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

incongruence between one's experienced/expressed gender and natal gender of at least 6 months in duration?			
6. Does documentation show at least two of the following: <ul style="list-style-type: none"> <li>• Marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics</li> <li>• Strong desire to rid of one's primary and/or secondary sex characteristics</li> <li>• Strong desire for the primary and/or secondary sex characteristics of other gender</li> <li>• Strong desire to be or be treated as the other gender</li> <li>• Strong conviction that one has the typical feelings and reactions of the other gender</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
7. 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?	<input type="checkbox"/>	<input type="checkbox"/>	
8. Are baseline laboratory values before hormonal transgender initiation available (e.g., for estradiol levels in female to male, or testosterone levels in males to female)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
9. Is there a monitoring plan in place? (e.g. evaluating the patient every 3 months in the first year of hormone therapy, testosterone/estradiol levels, hematocrit levels)	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
10. Does documentation show the following has been discussed with the member and parent/guardian: <ul style="list-style-type: none"> <li>• reproductive health counseling</li> <li>• risks/benefit and expectations of hormone therapy and monitoring plan</li> <li>• other applicable preventive screenings</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
11. Does documentation include written consent from the member and the member's parent/guardian, unless the member is emancipated?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
12. If the request is for leuprolide, does documentation show Tanner stage $\geq 2$ ?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
13. If the request is for leuprolide, is the request for Eligard?	<input type="checkbox"/>	<input type="checkbox"/>	<b>If no, clinical documentation must include a medical reason why the member cannot use the preferred agent Eligard</b>
<b>REAUTHORIZATION</b>			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does documentation demonstrate a positive clinical response to hormones?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Has the member's mental health status been reassessed and appropriately managed?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Are there current laboratory hormone levels and any other relevant monitoring values?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			

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: 07/31/2023  
Next Review Date: 07/31/2024  
Current Effective Date: 08/01/2023

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# 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)?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does the member have a Forced Vital Capacity of 80% or greater?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Has the member had a duration of the disease for 2 years or less?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Is the member currently taking riluzole OR have clinical documentation showing a contraindication to riluzole therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Does the member have documentation showing an ALSFRS-R score?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

**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: 05/11/2023  
Next Review Date: 05/11/2024  
Current Effective Date: 06/01/2023

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# 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
<b>Prophylaxis of Invasive Aspergillus or Candida Infection</b>			
1. Is the request for prophylaxis of Invasive Aspergillus Infection or Candida infection?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the member severely immunocompromised as defined by at least one of the following? <ul style="list-style-type: none"> <li>• Member is status post hematopoietic stem cell transplant with current, significant graft-versus-host disease receiving immunosuppressive therapies</li> <li>• Member has a hematologic malignancy with neutropenia</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>Fungal Infection Treatment</b>			
1. Is request made by, or in consultation with, an Infectious Disease Specialist?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Does the member have a diagnosis of one of the following? <ul style="list-style-type: none"> <li>• Refractory coccidioidomycosis,</li> <li>• Invasive mucormycosis,</li> <li>• Oropharyngeal candidiasis,</li> <li>• Invasive <i>Aspergillus</i> infection (Aspergillosis)</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

**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: 05/11/2023  
Next Review Date: 05/11/2024  
Current Effective Date: 06/01/2023

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# 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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Does the affected area exceed 10% body surface area?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Does the member have history of failure, contraindication, or intolerance to ALL of the following? <ul style="list-style-type: none"> <li>• Two medium to high potency corticosteroids (e.g., triamcinolone acetonide 0.1%, mometasone furoate 0.1%, betamethasone dipropionate 0.05%, desoximetasone 0.05%)</li> <li>• Topical calcineurin inhibitor, such as pimecrolimus or tacrolimus</li> <li>• Phototherapy</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

### REAUTHORIZATION

1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does clinical documentation show achievement and maintenance of positive clinical response?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

**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: 11/09/2023

Next Review Date: 11/09/2024

Current Effective Date: 12/01/2023

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# 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
<b>SEVERE ASTHMA</b>			
1. Does the member have a diagnosis of severe asthma and documentation of at least one of the following: <ul style="list-style-type: none"> <li>• Symptoms throughout the day</li> <li>• Nighttime awakenings, often 7 times per week</li> <li>• SABA use for symptom control occurs several times per day</li> <li>• Extremely limited normal activities</li> <li>• Lung function (percent predicted FEV1) &lt;60%</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Is the request made by an asthma specialist (allergist, immunologist, or pulmonologist)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Is Tezspire™ used as an add-on maintenance treatment to routine maintenance treatment that includes both of the following: <ul style="list-style-type: none"> <li>• A medium to high-dose inhaled corticosteroid</li> <li>• One other controller medication (e.g., long-acting beta agonist, leukotriene modifiers, etc.)</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Does clinical documentation show the member is ≥ 80% compliant for at least 5 months with prescribed inhalers?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Does clinical documentation show poor asthma control, defined by the following: <ul style="list-style-type: none"> <li>• ≥2 acute exacerbations in a 12-month period requiring additional medical treatment, including emergency</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

department (ED) visits, hospitalizations, or frequent office visits, etc.			
6. Does the member have a baseline forced expiratory volume in 1 second (FEV <sub>1</sub> ) < 80%? • Note: For members age 12 to 17, FEV <sub>1</sub> must be < 90%	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
7. 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	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
8. Will Tezspire™ be used in combination with anti-IL4, anti-IL5, or anti-IgE monoclonal antibody agents?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
9. Is smoking cessation addressed, if applicable?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>REAUTHORIZATION</b>			
1. Is the requesting for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Does clinical documentation show a positive clinical response to therapy with improvement from baseline?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
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: 11/09/2023  
 Next Review Date: 11/09/2024  
 Current Effective Date: 12/01/2023

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# 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: Kevzara 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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Does the member have a diagnosis of polymyalgia rheumatic (PMR)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Has the member been taking prednisone for at least 8 weeks (≥10 mg/day or equivalent)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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: <ul style="list-style-type: none"> <li>• Shoulder and/or hip girdle pain associated with inflammatory stiffness</li> <li>• Erythrocyte sedimentation rate (ESR) ≥30 mm/hr and/or C-reactive protein (CRP) ≥ 10mg/L?</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Has the member had an adequate trial and failure of methotrexate for at least 3 months?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

**REAUTHORIZATION**

1. Is the requesting for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
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2. Does the member have clinical documentation show absence of signs and symptoms of PMR and CRP < 10 mg/L?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>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.</b>			
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: 01/17/2024  
 Next Review Date: 01/17/2025  
 Current Effective Date: 02/01/2024

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# HEALTH | CHOICE

UTAH

## MEDICAL 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:**  INFed® (iron dextran),  Venofer® (iron sucrose),  Ferrlecit® (sodium ferric gluconate complex in sucrose)

**Non-preferred:**  Feraheme® (ferumoxytol),  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 $\leq 100\text{ng/mL}$ and one of the following diagnoses: <ul style="list-style-type: none"> <li>heart failure</li> <li>chronic kidney disease (CKD)</li> <li>hereditary hemorrhagic telangiectasia (HHT)</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Is the member currently pregnant with a serum ferritin concentration $\leq 20\text{ng/mL}$	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Has the member been diagnosed with iron deficiency anemia?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Has the member had a trial and failure to of oral iron therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Is the member losing iron from blood loss at a rate greater than they are able to absorb from the intestine?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Does the member have a gastrointestinal disorder (e.g. ulcerative colitis, Crohn's disease) in which oral iron therapy may aggravate therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
7. Is the member unable to maintain iron balance on hemodialysis?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
8. Is the member donating large amounts of blood for autotransfusion programs?	<input type="checkbox"/>	<input type="checkbox"/>	
9. Is the anemia chemotherapy-induced?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does documentation show a continued medical necessity and clinically significant response to therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
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: 03/27/2024  
 Next Review Date: 03/27/2025  
 Current Effective Date: 04/01/2024

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# HEALTH | CHOICE

UTAH

## PHARMACY PRIOR AUTHORIZATION REQUEST FORM KYMRIAH®

**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:**  Kymriah™ (tisagenlecleucel)

Dosing/Frequency: \_\_\_\_\_

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

Questions	Yes	No	Comments/Notes
1. Is the requesting provider in the Kymriah® REMS program?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does the member have an active infection, including hepatitis B, hepatitis C, human immunodeficiency virus (HIV), and influenza?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Does the member have an inflammatory disorder?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Does the member have adequate and stable liver, kidney, and cardiac function?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. If the member is a sexually active female of reproductive age, a negative pregnancy test must be documented	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Does the member have any of the following: <ul style="list-style-type: none"> <li>• Isolated extra-medullary disease</li> <li>• Concomitant genetic syndrome associated with BM failure states</li> <li>• Burkitt's lymphoma/leukemia</li> <li>• Grade 2 to 4 graft versus host disease</li> <li>• CNS prophylaxis treatment</li> <li>• History of primary CNS lymphoma or active CNS involvement by malignancy</li> <li>• Worsening of leukemia burden following lymphodepleting chemotherapy</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

### ACUTE LYMPHOBLASTIC LEUKEMIA

1. Is the request for treatment of acute lymphoblastic leukemia?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please Provide Documentation</b>
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2. Is the member between the ages of 3-25 years?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please Provide Documentation</b>
3. Are B cells CD 19 positive as confirmed by testing or analysis?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Does the member have relapsed or refractory disease?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Does the member have a Karnofsky score or Lansky score > 50?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>B- CELL LYMPHOMA</b>			
1. Is the request for treatment of B-cell lymphoma?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please Provide Documentation</b>
2. Is the member at least 18 years of age?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please Provide Documentation</b>
3. Does the member have CD-19 positive disease?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please Provide Documentation</b>
4. Does the member have primary central nervous system lymphoma?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please Provide Documentation</b>
5. Does the member have an Eastern Cooperative Oncology Group (ECOG) Performance status of 0 or 1?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please Provide Documentation</b>
6. Has the member been unresponsive or refractory to at least 2 lines of systemic therapy, which must include anti CD-20 therapy and an anthracycline containing regimen?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please Provide Documentation</b>
7. Does the member have disease progression or relapse post-autologous stem cell transplant?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please Provide Documentation</b>
8. Does the member have any of the following: <ul style="list-style-type: none"> <li>• Isolated extra-medullary disease</li> <li>• Concomitant genetic syndrome associated with BM failure states</li> <li>• Burkitt's lymphoma/leukemia</li> <li>• Grade 2 to 4 graft versus host disease</li> <li>• CNS prophylaxis treatment</li> <li>• History of primary CNS lymphoma or active CNS involvement by malignancy</li> <li>• Worsening of leukemia burden following lymphodepleting chemotherapy</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please Provide Documentation</b>
<b>REFRACTORY FOLLICULAR LYMPHOMA</b>			
1. Does documentation show a diagnosis of relapsing or refractory follicular lymphoma grade 1, 2, or 3A?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please Provide Documentation</b>
2. Is the member at least 18 years of age?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please Provide Documentation</b>
3. Does the member have an Eastern Cooperative Oncology Group (ECOG) Performance status of 0 or 1?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please Provide Documentation</b>
4. Does clinical documentation show ONE of the following criteria: <ul style="list-style-type: none"> <li>• No response or refractory to at least 2 lines of systemic therapy, which must include the following: <ul style="list-style-type: none"> <li>○ Anti-CD20 therapy</li> <li>○ An alkylating containing regimen</li> </ul> </li> <li>• Disease progression or relapsed during or within 6 months of anti-CD20 maintenance therapy following at least 2 lines of systemic therapy</li> <li>• Disease progression or relapse post-autologous stem cell transplant (ASCT)</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please Provide Documentation</b>

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**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-M003  
Origination Date: 01/01/2022  
Reviewed/Revised Date: 10/27/2022  
Next Review Date: 10/27/2023  
Current Effective Date: 11/01/2022

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# HEALTH | CHOICE

UTAH

## PRIOR AUTHORIZATION REQUEST FORM LUTATHERA®

**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:**  Lutathera® (lutetium Lu 177 dotatate)

Dosing/Frequency: \_\_\_\_\_

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

Questions	Yes	No	Comments/Notes
1. Is the request for somatostatin receptor-positive gastroenteropancreatic neuroendocrine tumors (GEP-NETs)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Is the member 18 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Is the prescriber an oncologist or physician that specializes in the treatment of GEP-NETs, or in consultation with an oncologist or physician that specializes in treatment of GEP-NETs?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Does the member have unresectable, locally advanced, or metastatic disease?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Did the member's disease progress while on somatostatin analog treatment or molecularly targeted therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Does the member have somatostatin receptor-positive foregut, midgut, and hindgut GEP-NETs on all target lesions that has been confirmed via NETSPOT or Octreoscan?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
7. Has the tumor been well-differentiated with a Ki-67 index $\leq$ 20%?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide pathology report</b>
8. Does documentation show the member's Karnofsky score?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
9. Will the member discontinue long-acting somatostatin analog therapy for at least 4 weeks prior to initiation?	<input type="checkbox"/>	<input type="checkbox"/>	
10. Will the member discontinue short-acting somatostatin analog therapy for at least 24 hours prior to Lutathera® initiation?	<input type="checkbox"/>	<input type="checkbox"/>	

11. Will Sandostatin LAR® depot be administered intramuscularly 4-24 hours after each Lutathera® dose?	<input type="checkbox"/>	<input type="checkbox"/>	
12. Will Lutathera® be administered under the control of physicians who are qualified by specific training and experience and are approved by an appropriate governmental agency authorized to license the use of radiopharmaceuticals?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>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.</b>			
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-M004  
 Origination Date: 01/01/2022  
 Reviewed/Revised Date: 06/28/2023  
 Next Review Date: 06/28/2024  
 Current Effective Date: 07/01/2023

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# HEALTH | CHOICE

UTAH

## PHARMACY 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® (brolocizumab-dbli),  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?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the requesting provider an ophthalmologist or in consultation with one?	<input type="checkbox"/>	<input type="checkbox"/>	
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)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Does the member have a baseline visual acuity score?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. For Beovu®, does documentation show a trial and failure of Avastin® and Eylea®?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. For Byooviz™, does documentation show a diagnosis of AMD, RVO or mCNV and a trial and failure of Avastin® and Eylea®?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
7. For Cimerli™, does documentation show a diagnosis of DME or DR and trial and failure of Avastin® and Eylea®?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
8. For Eylea®, does documentation show a trial and failure of Avastin®?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

9. For Lucentis®, does documentation show a trial and failure of Avastin®, Byooviz™ or Cimerli™, and Eylea®?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
10. For Macugen®, does documentation show a trial and failure of Avastin®, Byooviz™ or Cimerli™, and Eylea®?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
11. For Susvimo™, does documentation show a trial and failure of Avastin®, Byooviz™ or Cimerli™, and Eylea®?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
13. For Vabysmo™, does documentation show a trial and failure of Avastin®, Byooviz™ or Cimerli™, and Eylea®?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>REAUTHORIZATION</b>			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Do updated clinical notes show a positive response to therapy and a continued medical necessity?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
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: 03/16/2023  
 Next Review Date: 03/16/2014  
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# 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
<b>PROLIA® FOR OSTEOPOROSIS</b>			
1. Has the member been diagnosed with osteoporosis?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Does the member have a documented baseline bone mineral density (BMD) T-score of $\leq -2.5$ by DEXA scan?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Has the member had a 24-month trial and failure to a bisphosphonate?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>PROLIA® FOR BONE LOSS SECONDARY TO AROMATASE INHIBITORS</b>			
1. Has the member been diagnosed with breast cancer and is currently taking an aromatase inhibitor?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Does the member have a documented baseline bone mineral density (BMD) T-score of $< -1.0$ by DEXA scan?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Has the member had a 24-month trial and failure with a bisphosphonate?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>PROLIA® FOR HORMONE- SENSITIVE PROSTATE CANCER</b>			
1. Has the member been diagnosed with Hormone-Sensitive Prostate Cancer and currently taking androgen deprivation therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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 $>20\%$ ?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

3. Has the member had a 24-month trial and failure to a bisphosphonate?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>XGEVA®</b>			
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Does the member have a diagnosis of metastatic bone disease from solid tumor and has had a trial and failure to a bisphosphonate?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Has the member been diagnosed with hypercalcemia of malignancy refractory to bisphosphonate therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Has the member had a trial and failure of an intravenous bisphosphonate, unless contraindicated?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>REAUTHORIZATION</b>			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member's therapy been re-evaluated within the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Has the therapy shown to be effective with an improvement or stabilization in condition?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Does the member have a continued medical need for the therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
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: 09/14/2023  
 Next Review Date: 09/14/2024  
 Current Effective Date: 10/01/2023

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# 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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Is the requesting provider a neurologist with expertise in spinal muscular atrophy?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Does clinical documentation show one of the following: <ul style="list-style-type: none"> <li>• 5q SMA homozygous gene deletion or mutation</li> <li>• Compound heterozygote mutation</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Is the member ≤15 years of age?	<input type="checkbox"/>	<input type="checkbox"/>	
5. Is the member dependent on either invasive ventilation or tracheostomy?	<input type="checkbox"/>	<input type="checkbox"/>	
6. Does documentation contain a baseline platelet count?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
7. Does documentation include at least one of the following baseline motor ability scores: <ul style="list-style-type: none"> <li>• Hammersmith Infant Neurological Exam (HINE)</li> <li>• Hammersmith Functional Motor Scale Expanded (HFMSE)</li> <li>• Upper Limb Module Test (non-ambulatory)</li> <li>• Children’s Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND)</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
8. Has the member received treatment with Zolgensma®?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
9. Does clinical documentation show trial and failure or contraindication/intolerance to Evrysdi® (risdiplam)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

10. Is member currently taking Evrysdi® (risdiplam) or are there plans to start Evrysdi® (risdiplam)?			
<b>REAUTHORIZATION</b>			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member's therapy been re-evaluated within the past 7 months?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Does the member meet initial authorization criteria?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Has the member received treatment with Zolgensma®?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Does documentation show platelet counts prior to each dose?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Has the member responded to therapy with documentation showing maintenance or improvement in motor milestones?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
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: 05/22/2024  
 Next Review Date: 05/22/2025  
 Current Effective Date: 06/01/2024

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# 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?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the member male?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Does the member have a confirmed diagnosis of one of the following? <ul style="list-style-type: none"> <li>Primary hypogonadism</li> <li>Hypogonadotropic hypogonadism</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Does the member have 2 confirmed early morning low serum testosterone levels at least 24 hours apart, defined as one of the following: <ul style="list-style-type: none"> <li>Total testosterone(TT) &lt;464ng/dL (9.2nmol/L) for CDC certified TT assays</li> <li>Free testosterone (FT) level less than the laboratory's normal reference range</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Has the member had at least a 6-month trial and failure of injectable testosterone?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Has the member had at least a 6-month trial and failure of topical testosterone?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

#### REAUTHORIZATION

1. Is the requesting for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
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2. Does clinical documentation show continued medical necessity and that the treatment is effective?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
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: 09/14/2023  
 Next Review Date: 09/14/2024  
 Current Effective Date: 10/01/2023

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# HEALTH | CHOICE

UTAH

## PRIOR AUTHORIZATION REQUEST FORM YESCARTA®

**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:**  Yescarta® (axicabtagene ciloleucel)

Dosing/Frequency: \_\_\_\_\_

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

Questions	Yes	No	Comments/Notes
1. Is the request for Yescarta® for Relapse or Refractory Large B-cell Lymphoma?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the request for Yescarta for Large B-cell lymphoma that is refractory to first-line chemoimmunotherapy or that relapsed within 12 months of first-line chemoimmunotherapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Is the request for Yescarta® for Relapse or Refractory Follicular Lymphoma?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Is the member at least 18 years of age?	<input type="checkbox"/>	<input type="checkbox"/>	
5. Is the requesting provider in the Yescarta® REMS program?	<input type="checkbox"/>	<input type="checkbox"/>	
6. Does the member have CD-19 positive disease?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
7. Does the member meet at least one of the following: <ul style="list-style-type: none"> <li>• No response to at least 2 lines of systemic therapy which must include an anti CD-20 therapy and an anthracycline containing regimen</li> <li>• Disease progression or relapse post-autologous stem cell transplant (ASCT)</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
8. Has the member been found to be negative for active infections, including Hepatitis B, Hepatitis C, Human Immunodeficiency Virus (HIV), and influenza?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
9. Does the member have adequate and stable kidney, liver, and cardiac function?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

10. Does documentation show the members Eastern Cooperative Oncology Group (ECOG) Performance status?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
11. If a sexually active female of reproductive age, does the member have a negative pregnancy test?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
12. Does the member have any of the following: <ul style="list-style-type: none"> <li>• Grade 2 to 4 graft versus host disease</li> <li>• Presence of an autoimmune disease requiring immune suppression</li> <li>• History of primary central nervous system lymphoma or active CNS involvement by malignancy</li> <li>• Cardiac ejection fraction &lt;50%, evidence of pericardial effusion, or clinically significant pleural effusion</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>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.</b>			
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-M009  
Origination Date: 01/01/2022  
Reviewed/Revised Date: 06/28/2023  
Next Review Date: 06/28/2024  
Current Effective Date: 07/01/2023

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# 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?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does the member have a BMI ≤40?	<input type="checkbox"/>	<input type="checkbox"/>	
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?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Does the member have a diagnosis of grade II or grade III primary osteoarthritis of the knee?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Does the member have a diagnosis of grade IV osteoarthritis of the knee and is contraindicated for a total knee replacement?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Is the member experiencing moderate to severe functional impairment with at least one of the following: <ul style="list-style-type: none"> <li>• Functional impairment with poor mobility</li> <li>• Increased pain with prolonged standing</li> <li>• Frequent flares requiring use of analgesics or NSAIDs, corticosteroids, etc.</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
7. Has the member had a trial and failure of ALL of the following: <ul style="list-style-type: none"> <li>• Physician directed exercise or a physical therapy program</li> <li>• Simple analgesics such as acetaminophen and/or topical capsaicin AND prescription strength NSAIDs for at least 3 months</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

<ul style="list-style-type: none"> <li>• Orthotic device like a knee brace</li> <li>• History of a positive but inadequate response to at least one other intra-articular glucocorticoid injection of the knee</li> </ul>			
<p><b>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.</b></p>			
<p>Additional information:</p>			
<p>Physician Signature:</p>			

**\*\*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: 06/28/2023  
 Next Review Date: 06/28/2024  
 Current Effective Date: 07/01/2023

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## MEDICAL PHARMACY 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
<b>DUPUYTREN'S CONTRACTURE</b>			
1. Does the member have a confirmed diagnosis of Dupuytren's contracture with palpable cord of at least one finger?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Is the member 18 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Does the palpable cord involve the metacarpophalangeal (MP) joint or the proximal interphalangeal (PIP) joint?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Has the member had a fasciectomy or fasciotomy within 90 days prior to the first injection?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>PEYRONIE'S DISEASE</b>			
1. Does the member have a confirmed diagnosis of Peyronie's disease with palpable plaque?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Is the member 18 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Is the prescribing provider an urologist?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Does member have a curvature deformity of at least 30 degrees at the start of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Is the curvature deformity caused by congenital ventral penile curvature or curvature associated with epispadias?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Is member experiencing clinical complications from Peyronie's such as pain and/or difficulty with urination?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

REAUTHORIZATION			
DUPUYTREN'S CONTRACTURE			
1. Does the member meet the initial criteria?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
2. Does documentation show the MP or PIP contracture remains?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
3. Was the last treatment $\geq$ 4 weeks ago?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Has the member received > 3 injections per cord?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
PEYRONIE'S DISEASE			
1. Does documentation show that a maximum of 4 treatment cycles have been received?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
2. Is the member experiencing clinical complications from Peyronie's such as pain and/or difficulty with urination?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
3. Does documented curvature deformity remain at $\geq$ 15 degrees since the last treatment cycle?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Do clinic notes document that a penile modeling procedure has been performed 1 to 3 days after each injection?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
5. Was the last treatment cycle $\geq$ 6 weeks ago?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
<b>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.</b>			
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: 02/17/2023  
 Next Review Date: 02/17/2024  
 Current Effective Date: 03/01/2023

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# HEALTH CHOICE

UTAH

## PHARMACY PRIOR AUTHORIZATION REQUEST FORM ZOLGENSMA®

**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:**  Zolgensma® (onasemnogene abeparvovec-xioi)

Dosing/Frequency: \_\_\_\_\_

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

Questions	Yes	No	Comments/Notes
1. Does the member have a genetically confirmed diagnosis of spinal muscular atrophy (SMA) with bi-allelic mutations in the survival motor neuron 1 (SMN1) gene and ≤ 3 copies of SMN2?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Is the medication prescribed by or in consultation with a physician who specializes in the treatment of SMA?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Will the member be less than 2 years of age at the time of administration?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Is the member's weight ≤13.5 kg?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Does the member have advanced SMA with any of the following: <ul style="list-style-type: none"> <li>• Complete paralysis of limbs</li> <li>• Invasive ventilator support (tracheostomy)</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Does documentation provide anti-AAV9 antibody titer ≤1:50 as determined by Enzyme-linked Immunosorbent Assay (ELISA) Binding immunoassay?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
7. Was the member born prematurely?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
8. Has the member received Zolgensma® before?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

9. Is the member currently receiving routine concomitant SMN modifying therapy, e.g., Spinraza® (nusinersen), Evrysdi® (risdiplam)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
Additional information:			
Physician Signature:			

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

Policy PHARM-HCU-M012  
 Origination Date: 01/01/2022  
 Reviewed/Revised Date: 10/27/2022  
 Next Review Date: 10/27/2023  
 Current Effective Date: 11/01/2022

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# HEALTH | CHOICE

UTAH

## PRIOR AUTHORIZATION REQUEST FORM 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
<b>PAROXYSMAL NOCTURNAL HEMOGLOBINURIA (PNH)</b>			
1. Is the member 18 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the diagnosis of Paroxysmal Nocturnal Hemoglobinuria (PNH) confirmed via flow cytometry?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Is the member transfusion dependent requiring at least four transfusions in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Does the member have a history of a major thrombotic event?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Does the member have high lactate dehydrogenase (LDH) activity with serum levels $\geq 1.5$ times the upper limit of normal and have clinical symptoms?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Has the member had Neisseria meningitidis vaccination at least 2 weeks prior to start date?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
7. Is the prescribing physician enrolled in the Soliris® or Ultomiris® Risk Evaluation and Mitigation Strategies (REMS) program?	<input type="checkbox"/>	<input type="checkbox"/>	
8. If the request is for Soliris®, has the member tried and failed Ultomiris®, unless contraindicated?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>ATYPICAL HEMOLYTIC UREMIC SYNDROME (aHUS)</b>			
1. Does the member have a diagnosis of Atypical Hemolytic Uremic Syndrome (aHUS)?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has Shiga toxin-related hemolytic uremic syndrome been ruled out?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

3. Does the member have a normal ADAMTS-13 level?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Has the member had the Neisseria meningitidis vaccination?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Is the prescribing physician enrolled in Soliris® or Ultomiris® REMS program?	<input type="checkbox"/>	<input type="checkbox"/>	
6. If the request is for Soliris®, has the member tried and failed Ultomiris®, unless contraindicated?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>NEUROMYELITIS OPTICA SPECTRUM DISORDER (NMOSD)</b>			
1. Is the prescribing provider a neurologist who specializes in treating NMOSD?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does the member have a confirmed diagnosis of NMOSD including both: • Anti-aquaporin-4 (AQP4) positive • At least one of the core clinical characteristics	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Has the member had at least one relapse requiring rescue therapy in the last 12 months or two or more relapses requiring rescue therapy in the last 24 months?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Is there documentation of an Expanded Disability Status Score (EDSS) of ≤8?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Has the member had an adequate trial and failure of Enspryng®, Ruxience® AND Uplizna™?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Is the prescribing physician enrolled in Soliris® REMS program?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>REAUTHORIZATION</b>			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. <b>Reauthorization of PNH treatment:</b> Has a clinically significant response been demonstrated (e.g. decrease in LDH from baseline, improvement in hemoglobin, or decrease in red blood cell transfusion frequency)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. <b>Reauthorization of aHUS treatment:</b> 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)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. <b>Reauthorization of gMG treatment:</b> Has a clinically significant response been demonstrated (e.g. MG-ADL score reduction of 2 points or more, QMG score reduction of 3 points or more)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. <b>Reauthorization of NMOSD treatment:</b> Has a clinically significant response been demonstrated (e.g. decrease in relapse rate, improvement or stabilization of symptoms associated with relapse, improvement in EDSS score)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			

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Additional information:

Physician's Signature:

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Policy: PHARM-HCU-068  
Origination Date: 01/01/2022  
Reviewed/Revised Date: 09/14/2023  
Next Review Date: 09/14/2024  
Current Effective Date: 10/01/2023

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# 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.**

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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:	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?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the member seen and followed by a neurologist/pediatric neurologist who is familiar with treatment of Batten disease?	<input type="checkbox"/>	<input type="checkbox"/>	
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Is the member ambulatory?	<input type="checkbox"/>	<input type="checkbox"/>	

#### REAUTHORIZATION

1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does the member meet initial authorization criteria?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Has the member experienced unacceptable toxicity to the therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Have CSF testing within the past 3 months been documented?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Has the member had a clinically significant response to the therapy with a stability/lack of decline in motor	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
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: 01/19/2023  
 Next Review Date: 01/19/2024  
 Current Effective Date: 02/01/2023

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# HEALTH CHOICE

UTAH

## PRIOR AUTHORIZATION REQUEST FORM

### TEPEZZA™

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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:	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?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the prescriber an ophthalmologist?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Does the member have a diagnosis of Graves' disease?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Does the member have a diagnosis of active moderate to severe Thyroid Eye Disease with clinical complications? • Low disease activity is excluded	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Did ocular symptoms begin within 9 months of the baseline assessment?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
7. Is the member euthyroid?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
8. Does the provider attest that smoking cessation has been addressed with the member?	<input type="checkbox"/>	<input type="checkbox"/>	
9. Has the member had a 1-month trial and failure or contraindication/intolerance to systemic corticosteroids at the maximum tolerated dose?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

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™?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>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.</b>			
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: 09/14/2023  
 Next Review Date: 09/14/2024  
 Current Effective Date: 10/01/2023

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# HEALTH | CHOICE

UTAH

## PRIOR AUTHORIZATION REQUEST FORM Neuromyelitis Optica Spectrum Disorder (NMOSD)

**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)

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)?	<input type="checkbox"/>	<input type="checkbox"/>	
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 postrema syndrome, acute brainstem syndrome, symptomatic narcolepsy, acute diencephalic clinical syndrome, or symptomatic cerebral syndrome with brain lesions?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Is an Expanded Disability Status Score (EDSS) score equal to 8 or less?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Has the member had an adequate trial and failure of any of the medications listed in this policy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

### REAUTHORIZATION

1. Is the request for reauthorization of therapy?	Yes	No	
2. Does documentation show a clinically significant response to therapy demonstrated by one of the following:	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<ul style="list-style-type: none"> <li>• Decrease in relapse rate</li> </ul>			

<ul style="list-style-type: none"> <li>• Improvement of symptoms or stabilization of symptoms associated with relapse</li> <li>• Improvement in EDSS score</li> </ul>			
<p><b>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.</b></p>			
<p>Additional information:</p>			
<p>Physician Signature:</p>			

**\*\*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: 05/11/2023  
 Next Review Date: 05/11/2024  
 Current Effective Date: 06/01/2023

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# 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: \_\_\_\_\_

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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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.	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Has the member tried and failed aprepitant and fosaprepitant in combination with palonosetron?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Is the request for the prevention of nausea and vomiting associated with anthracycline plus cyclophosphamide (AC) chemotherapy? Documentation must show medical necessity.	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

### REAUTHORIZATION

1. Is the request for reauthorization of therapy?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
2. Does documentation show the therapy was effective with a positive clinical response to therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

**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: 07/31/2023  
Next Review Date: 07/31/2024  
Current Effective Date: 08/01/2023

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# 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?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does documentation show a diagnosis of chronic gout with hyperuricemia?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Does documentation demonstrate one of the following: <ul style="list-style-type: none"> <li>• 3 or more gout flares in the previous 18 months</li> <li>• 1 or more tophus</li> <li>• Presence of chronic gouty arthritis?</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Does documentation show a baseline serum uric acid level > 8mg/dL?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
7. For members with African American or Mediterranean ancestry, has the member been screened and found negative for G6PD deficiency?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

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.	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>REAUTHORIZATION</b>			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does clinical documentation show an improvement or stabilization of the condition?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Does documentation show a recent uric acid level of < 6 mg/dL?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
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: 06/28/2023  
 Next Review Date: 06/28/2024  
 Current Effective Date: 07/01/2023

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# HEALTH CHOICE

UTAH

## MEDICAL PHARMACY PRIOR AUTHORIZATION REQUEST FORM

### TECARTUS®

**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:**  Tecartus® (brexucabtagene autoleucel)

Dosing/Frequency: \_\_\_\_\_

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

Questions	Yes	No	Comments/Notes
<b>MANTLE CELL LYMPHOMA</b>			
1. Is the member 18 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does the member have a diagnosis of relapse or refractory mantle cell lymphoma?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Was the member refractory, or had no response, to all of the following: <ul style="list-style-type: none"> <li>• Anthracycline or bendamustine-containing regimen</li> <li>• Anti-CD20 therapy, such as rituximab</li> <li>• Bruton's Tyrosine Kinase (BTK) inhibitors, such as ibrutinib or acalabrutinib?</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Does the member have a histological confirmation of cyclin D1 overexpression or presence of the translocation t(11;14)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Does the member have at least one measurable lesion per the Lugano Classification? <ul style="list-style-type: none"> <li>• Lymph nodes: the longest diameter in axial plane is &gt;1.5 cm</li> <li>• Extranodal lesions: the longest diameter in axial plane is &gt; 1.0 cm</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Does the member have adequate bone marrow reserve with all of the following: <ul style="list-style-type: none"> <li>• Platelet count <math>\geq</math> 75,000/<math>\mu</math>L</li> <li>• Absolute neutrophil count (ANC) <math>\geq</math> 1,000 cells/<math>\mu</math>L</li> <li>• Absolute lymphocyte count (ALC) <math>\geq</math> 100 cells/<math>\mu</math>L</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

7. Does the member have a Karnofski score $\geq$ 70 or Eastern Cooperative Oncology Group (ECOG) score $<$ 2?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
8. Does the member have a documented ability to tolerate a lymphodepleting chemotherapy regimen of cyclophosphamide 500mg/m <sup>2</sup> intravenously and fludarabine 30mg/m <sup>2</sup> intravenously on the fifth, fourth, and third days before Tecartus™ infusion?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
9. Does the member have adequate and stable renal, cardiac, and pulmonary function with all of the following: <ul style="list-style-type: none"> <li>• Creatinine clearance <math>\geq</math> 60mL/min</li> <li>• Cardiac ejection fraction <math>\geq</math> 50% and no evidence of pericardial effusion determined by an echocardiogram</li> <li>• Baseline oxygen saturation <math>&gt;</math> 92% on room air?</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
10. Dose the member have any of the following: <ul style="list-style-type: none"> <li>• Previous allogeneic hematopoietic cell transplant (HSCT)</li> <li>• Prior treatment with chimeric antigen receptor therapy or other genetically modified T-cell therapy; or is being considered for treatment with any other gene therapy</li> <li>• Presence of fungal, bacterial, viral, or other infection that is uncontrolled requiring IV antimicrobials for management prior to Tecartus™ infusion</li> <li>• Active inflammatory disorders</li> <li>• Active hepatitis B (HBsAG positive) or hepatitis C (anti-HCV positive) virus, if viral load is detectable</li> <li>• History of central nervous system lymphoma</li> <li>• Active central nervous system (CNS) lymphoma or CNS disorders by imaging</li> <li>• Detectable malignant cells in the cerebrospinal fluid or brain metastases?</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	
11. Has the member received live vaccines within 6 weeks prior to the start of lymphodepleting chemotherapy?	<input type="checkbox"/>	<input type="checkbox"/>	
12. Will Tecartus™ be given at a certified center to administer Tecartus™?	<input type="checkbox"/>	<input type="checkbox"/>	
13. Has the member and the requesting provider enrolled in the Yescarta® and Tecartus™ REMS program?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>B-CELL PRECURSOR ACUTE LYMPHOBLASTIC LEUKEMIA (ALL)</b>			
1. Has the member received a previous treatment course of the requested medication or another CD19-directed chimeric antigen receptor (CAR-T) therapy, or any prior CD19 directed therapy other than blinatumomab?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Does the member have Philadelphia chromosome-negative disease that is relapsed or refractory as defined as one of the following: <ul style="list-style-type: none"> <li>• Primary refractory disease; <i>or</i></li> <li>• First relapse with remission of 12 months or less; <i>or</i></li> <li>• Relapsed or refractory disease after at least 2 previous lines of systemic therapy; <i>or</i></li> <li>• Relapsed or refractory disease after allogeneic stem cell transplant (allo-SCT)</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

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3. Does the member have Philadelphia chromosome-positive disease and meets either of the following: <ul style="list-style-type: none"> <li>Relapsed or refractory disease despite treatment with at least 2 different tyrosine kinase inhibitors (TKIs) (e.g., bosutinib, dasatinib, imatinib, nilotinib, ponatinib); or</li> <li>The member is intolerant to TKI therapy</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Does the member have morphological disease in the bone marrow?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Does the member have an ECOG performance status of 0 to 2?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Does the member have adequate and stable kidney, liver, pulmonary, and cardiac function?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
7. Does the member have active hepatitis B, active hepatitis C, or any active uncontrolled infection?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
8. Does the member have active graft versus host disease?	<input type="checkbox"/>	<input type="checkbox"/>	
9. Does the member have an active inflammatory disorder?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>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.</b>			
Additional information:			
Physician Signature:			

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

Policy: PHARM-HCU-M031  
Origination Date: 01/01/2022  
Reviewed/Revised Date: 04/19/2023  
Next Review Date: 04/19/2024  
Current Effective Date: 05/01/2023

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# HEALTH | CHOICE

UTAH

## PRIOR AUTHORIZATION REQUEST FORM

### VYEPTI™

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**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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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: <ul style="list-style-type: none"> <li>• A calcium channel blocker</li> <li>• An antidepressant</li> <li>• An anticonvulsant</li> <li>• An angiotensin-converting enzyme (ACE) inhibitor</li> </ul> <b>Note:</b> if the member cannot try a beta-blocker, then 2 migraine prevention medication classes listed above must be tried.	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Has the member tried and failed, or is contraindicated to, preferred agents Ajovy®, Emgality®, and Aimovig®?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

### REAUTHORIZATION

1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does clinical documentation show a positive response to therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

**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: 05/11/2023  
Next Review Date: 05/11/2024  
Current Effective Date: 06/01/2023

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# HEALTH | CHOICE

UTAH

## PRIOR AUTHORIZATION REQUEST FORM ABECMA®

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**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:**  Abecma® (idecabtagene vicleucel)

Dosing/Frequency: \_\_\_\_\_

Questions	Yes	No	Comments/Notes
1. Is the member 18 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the requesting provider an oncologist?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Has the member been diagnosed with multiple myeloma with measurable disease including at least one of the following: <ul style="list-style-type: none"> <li>• Serum M-protein <math>\geq 1</math> g/dL</li> <li>• Urine M-protein <math>\geq 200</math> mg/24 hours</li> <li>• Serum free light chain (FLC) assay <math>\geq 10</math> mg/dL provided serum FLC ratio is abnormal?</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Does the member have relapsed or refractory disease, defined as progression after $\geq 4$ lines of systemic therapy? Prior therapy must include all the following: <ul style="list-style-type: none"> <li>• Anti-CD38 antibody (e.g. isatuximab or daratumumab)</li> <li>• Proteasome inhibitor (e.g. ixazomib, bortezomib, or carfilzomib)</li> <li>• Immunomodulatory drug (e.g. thalidomide, pomalidomide, lenalidomide)</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Does the member have an Eastern Cooperative Oncology Group (ECOG) performance status of 0 or 1?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Does documentation show an absence of active infection, including Hepatitis B, Hepatitis C, Human Immunodeficiency Virus (HIV), and influenza?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

7. Does the member have adequate bone marrow reserve defined by absolute neutrophil count (ANC) $\geq$ 1000 and platelet count $\geq$ 50,000 cells/ $\mu$ L?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
8. Does the member have any of the following: <ul style="list-style-type: none"> <li>• Creatinine clearance &lt; 45 mL/min</li> <li>• Alanine aminotransferase (ALT) &gt; 2.5 times the upper limit of normal</li> <li>• Ejection fraction &lt; 45%</li> <li>• Active inflammatory disorder</li> <li>• History of chimeric antigen receptor therapy (CAR-T) or other genetically modified T-cell therapy</li> <li>• History of allogeneic stem cell transplant?</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
9. For sexually active females of reproductive age, does the member have a negative pregnancy test?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
10. Does the member have a presence or history of central nervous system involvement with myeloma?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
11. Is the member and the requesting provider enrolled in the Abecma <sup>®</sup> REMS program?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>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.</b>			
Additional information:			
Physician Signature:			

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

Policy PHARM-HCU-M033  
Origination Date: 01/01/2022  
Reviewed/Revised Date: 05/11/2023  
Next Review Date: 05/11/2024  
Current Effective Date: 06/01/2023

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# HEALTH | CHOICE

UTAH

## PRIOR AUTHORIZATION REQUEST FORM

### BREYANZI®

**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:**  Breyanzi® (lisocabtagene maraleucel)

Dosing/Frequency: \_\_\_\_\_

Questions	Yes	No	Comments/Notes
1. Is the member 18 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does documentation show the member has relapsed or refractory large B-cell lymphoma, including one of the following: <ul style="list-style-type: none"> <li>• Diffuse large B-cell lymphoma (DLBCL) not otherwise specified</li> <li>• High-grade B-cell lymphoma</li> <li>• Primary mediastinal large B-cell lymphoma</li> <li>• Follicular lymphoma grade 3B</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Does the member have relapsed or refractory disease after at least 2 lines of systemic therapy, which must include both of the following: <ul style="list-style-type: none"> <li>• Anti-CD20 therapy</li> <li>• Anthracycline containing regimen</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Does the member have an Eastern Cooperative Oncology Group (ECOG) performance status of 0 or 1?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Does documentation show an absence of active infection, including Hepatitis B, Hepatitis C, Human Immunodeficiency Virus (HIV), and influenza?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Does the member have any of the following: <ul style="list-style-type: none"> <li>• CrCl &lt; 30mL/min</li> <li>• ALT &gt; 5 times the upper limit of normal</li> <li>• Left ventricular ejection fraction &lt; 40%</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

<ul style="list-style-type: none"> <li>History of chimeric antigen receptor therapy (CAR-T) or other genetically modified T-cell therapy</li> </ul>			
7. For sexually active females of reproductive age, does the member have a negative pregnancy test within 1 month of therapy initiation?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
8. Is the member and requesting provider enrolled in the Breyanzi® REMS program?	<input type="checkbox"/>	<input type="checkbox"/>	
9. Does the member have a history of primary central nervous system (CNS) lymphoma or active central nervous system (CNS) involvement by malignancy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
Additional information:			
Physician Signature:			

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

Policy PHARM-HCU- M034  
Origination Date: 01/01/2022  
Reviewed/Revised Date: 05/11/2023  
Next Review Date: 05/11/2024  
Current Effective Date: 06/01/2023

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# 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)?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does the member have a diagnosis of PH1 confirmed by both of the following: <ul style="list-style-type: none"> <li>Metabolic testing shows elevated urinary oxalate excretion persistently &gt; 0.7mmol/1.73m<sup>2</sup>/day OR for those less than 6 years of age a urinary oxalate/serum creatinine ratio &gt; the ULN for the member's age</li> <li>Genetic testing confirms a mutation in the alanine glyoxylate aminotransferase (AGXT) gene</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Has the member received a liver transplant?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Does the member have an estimated glomerular filtration rate (eGFR) > 30mL/min/1.73m <sup>2</sup> ?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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 <sup>2</sup> )?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

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)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
8. Has the member tried and failed, is currently taking, or has a contraindication/intolerance to, pyridoxine (Vitamin B6) for $\geq 3$ months without a positive response (defined as a reduction of $> 30\%$ in urinary oxalate excretion)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>REAUTHORIZATION</b>			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Has the member experienced unacceptable drug toxicity to therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
4. Has the member received a liver transplant?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>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.</b>			
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  
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# 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
<b>KETAMINE</b>			
1. Does the member have a diagnosis of moderate to severe major depressive disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Is the member taking an antidepressant and will treatment with an antidepressant continue while taking ketamine?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Does the member have a recent history of substance abuse or alcohol use disorder?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>REAUTHORIZATION</b>			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has member been compliant with their primary antidepressant if applicable?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Does clinical documentation show a continued medical necessity and a positive clinical response?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

**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: 11/09/2023  
Next Review Date: 11/09/2024  
Current Effective Date: 12/01/2023

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# HEALTH | CHOICE

UTAH

## MEDICAL PHARMACY 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
<b>MODERATE TO SEVERE SYSTEMIC LUPUS ERYTHEMATOSUS (SLE)</b>			
1. Does the member have a diagnosis of moderate to severe systemic lupus erythematosus (SLE)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Have laboratory tests been completed indicating the presence of autoantibodies (ANA, Anti-dsDNA, Anti-Sm, Anti-Ro/SSA, Anti-La/SSB)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Is the requesting provider a rheumatologist or in consultation with a rheumatologist?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Does the member have a Systemic Lupus Erythematosus Disease Activity Index 2000 (SLEDAI-2K) score of ≥ 6 points?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Does the member have a contraindication, intolerance or failure to Benlysta®?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Is the member receiving Saphnelo™ in combination with a biologic agent, Benlysta® or cyclophosphamide?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
7. Does the member have active musculoskeletal or cutaneous disease that is unresponsive to standard therapy with glucocorticoids, antimalarials and/or other immunosuppressive agents?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

8. Does the member have corticosteroid-dependent disease (prednisone equivalent dose $\geq 7.5$ mg/day) or trialed and failed both of the following: <ul style="list-style-type: none"> <li>hydroxychloroquine AND</li> <li>at least 1 immunosuppressant (e.g., azathioprine, methotrexate, mycophenolate, cyclosporine, cyclophosphamide)</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
9. Is the member at least 80% compliant for at least 6 months with their baseline therapy (i.e. glucocorticoids, immunosuppressants and/or antimalarials)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
10. Will the member use Saphnelo™ concurrently with baseline therapy, unless the member has a contraindication or intolerance to all?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
11. Does the member have severe active lupus nephritis or severe active central nervous system lupus (e.g., generalized seizures, psychosis, stroke, peripheral neuropathies)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>REAUTHORIZATION</b>			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member shown a positive clinical response to therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Has the member been compliant with baseline therapy during Saphnelo™ administration, unless otherwise contraindicated?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Is the member receiving Saphnelo™ in combination with a biologic agent or Benlysta®?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Does the member have severe active central nervous system lupus or severe active lupus nephritis?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
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: 02/17/2023  
 Next Review Date: 02/17/2024  
 Current Effective Date: 03/01/2023

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# 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
<b>RELAPSED OR REFRACTORY MULTIPLE MYELOMA</b>			
1. Is the request made by an oncologist?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Is the member 18 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Does the member have a diagnosis of multiple myeloma with measurable disease including at least one of the following: <ul style="list-style-type: none"> <li>• Serum monoclonal paraprotein (M-protein) ≥ 1 g/dL</li> <li>• Urine M-protein ≥ 200 mg/24 hours</li> <li>• Serum immunoglobulin free light chain (FLC) assay ≥ 10 mg/dL and abnormal serum immunoglobulin kappa lambda free light chain ratio</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Does the member have relapsed or refractory disease, defined as progression after ≥ 4 lines of systemic therapy and includes all of the following: <ul style="list-style-type: none"> <li>• Proteasome inhibitor (e.g., ixazomib, bortezomib, or carfilzomib)</li> <li>• Anti-CD38 antibody (e.g., isatuximab or daratumumab)</li> <li>• Immunomodulatory agent (e.g., thalidomide, pomalidomide, lenalidomide)</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Does the member have an Eastern Cooperative Oncology Group (ECOG) grade of 0 or 1?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Does the member have adequate hematology markers defined by all of the following:			

<ul style="list-style-type: none"> <li>• Platelet count <math>\geq</math> 50,000 cells/uL</li> <li>• Absolute Neutrophil Count <math>\geq</math> 750 cells/uL</li> <li>• Hemoglobin <math>\geq</math> 8.0 g/dL</li> </ul>			
<p>7. Does the member have any of the following:</p> <ul style="list-style-type: none"> <li>• Hepatic transaminases <math>&gt;</math> 3 times the upper limit of normal</li> <li>• Creatinine clearance <math>&lt;</math> 40 mL/min</li> <li>• Left Ventricular Ejection Fraction (LVEF) <math>&lt;</math> 45%</li> <li>• Active systemic viral, bacterial, or uncontrolled fungal infection. Note: Documentation must show absence of active Hepatitis B, Hepatitis C, and Human Immunodeficiency Virus (HIV)</li> <li>• History of chimeric antigen receptor therapy (CAR-T) or other genetically modified T-cell therapy</li> <li>• 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)</li> <li>• An autologous stem cell transplant <math>\leq</math> 12 weeks before apheresis</li> <li>• Presence or history of central nervous system involvement with myeloma</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<p>8. Are the member and requesting provider enrolled in the Carvykti™ Risk Evaluation and Mitigation Strategy (REMS) program?</p>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<p><b>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.</b></p>			
<p>Additional information:</p>			
<p>Physician Signature:</p>			

**\*\*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

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# HEALTH | CHOICE

UTAH

## PRIOR AUTHORIZATION REQUEST FORM

### Zynteglo®

**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:**  Zynteglo® (betibeglogene autotemcel)

Dosing/Frequency: \_\_\_\_\_

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

Questions	Yes	No	Comments/Notes
1. Is the request made by a board-certified hematologist and will be administered in a Qualified Treatment Center?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does the member have a diagnosis of non-β <sup>0</sup> /β <sup>0</sup> genotype Beta thalassemia confirmed by hemoglobin electrophoresis or high-performance liquid chromatography (HPLC)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Does clinical documentation show transfusion dependence including transfusions of at least 100 ml per kilogram of body weight of packed red cells per year in the 2 years before enrollment OR at least 8 transfusions per year in the 2 years before enrollment?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Is the member between the ages of 4 and 34 years?	<input type="checkbox"/>	<input type="checkbox"/>	
5. Does clinical documentation show haematopoietic stem cell transplantation (HSCT) is appropriate but a human leukocyte antigen (HLA)-matched related HSC donor is not available?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Does clinical documentation show an absence of active infections, including Hepatitis B, Hepatitis C, Human T-lymphotrophic virus (HTLV), and Human Immunodeficiency Virus (HIV) from within the past 3 months?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
7. Does clinical documentation show WBC count ≥ 3 x 10 <sup>9</sup> /L and platelet count ≥ 100 x 10 <sup>9</sup> /L?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
8. Does documentation show a negative pregnancy test if female?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

#### REAUTHORIZATION

Not applicable. Authorization is limited to a one-time authorization per lifetime

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- M042  
Origination Date: 10/05/2022  
Reviewed/Revised Date: 01/19/2023  
Next Review Date: 01/19/2024  
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# HEALTH CHOICE

UTAH

## PHARMACY PRIOR AUTHORIZATION REQUEST FORM

### LUNSUMIO™

**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:**  Lunsumio™ (mosunetuzumab-axgb)

Dosing/Frequency: \_\_\_\_\_

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

Questions	Yes	No	Comments/Notes
1. Does documentation show histologically confirmed diagnosis of relapsing or refractory follicular lymphoma grade 1, 2, or 3A?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Does the member have an Eastern Cooperative Oncology Group (ECOG) Performance status of 0 or 1?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Does documentation show no response or refractory to at least 2 lines of systemic therapy, including both of the following: <ul style="list-style-type: none"> <li>• Anti-CD20 therapy</li> <li>• An alkylating containing regimen</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Does the member have current or past central nervous system (CNS) involvement?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. For females with reproductive potential: <ul style="list-style-type: none"> <li>• Is there documentation of a negative pregnancy test prior to the start of therapy?</li> <li>• Has the member been counseled on the use of effective contraception during treatment and advised of the pregnancy risks associated with treatment?</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

#### REAUTHORIZATION

1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member had a complete response based on imaging and bone marrow examination?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Does the member have a partial response on stable disease in response to treatment with Lunsumio™ after 8 cycles?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

**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-M043  
Origination Date: 03/01/2023  
Reviewed/Revised Date: 03/16/2023  
Next Review Date: 03/16/2014  
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# 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?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does the member have a diagnosis of Stage 2, Type 1 Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Is the member between the ages of 8-45 years old?	<input type="checkbox"/>	<input type="checkbox"/>	
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	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Does the member have at least two positive pancreatic islet autoantibodies detected in two samples within 6 months of request?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Does the member have a 1 <sup>st</sup> or 2 <sup>nd</sup> degree relative with Type 1 Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
7. Has the member been previously treated with Tzield?	<input type="checkbox"/>	<input type="checkbox"/>	

**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: 05/11/2023  
Next Review Date: 05/11/2024  
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# 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
<b>CHRONIC OR PERSISTENT IMMUNE/ IDIOPATHIC THROMBOCYTOPENIA (ITP)</b>			
1. Does documentation show a diagnosis of chronic or persistent immune/idiopathic thrombocytopenia (ITP)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Is the request made by a hematologist or oncologist?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Does documentation show the member's platelet count is less than 30,000/mcL?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Has the member had an adequate trial and failure with corticosteroids, unless contraindicated? <ul style="list-style-type: none"> <li>• 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</li> <li>• Failure defined as platelet count not increasing to at least 50,000/mcL or continued requirement for steroids after 3 months of treatment</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

### 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)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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### REAUTHORIZATION

#### CHRONIC OR PERSISTENT IMMUNE/ IDIOPATHIC THROMBOCYTOPENIA (ITP)

1. Is the request for reauthorization of ITP therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
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2. Is there documentation of recent platelet count of 30,000-150,000/mcL?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Does documentation show the medication is providing a clinical benefit for the member?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
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  
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 Next Review Date: 05/19/2024  
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# HEALTH | CHOICE

UTAH

## PHARMACY 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 888-509-8142.**

**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 855-864-1404

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. 1<sup>st</sup> line preferred agents:
  - A. Rystiggo® (rozanolixizumab-noli) subcutaneous infusion, Vyvgart® (efgartigimod alfa-fcab) intravenous infusion
2. 2<sup>nd</sup> 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
<b>MYASTHENIA GRAVIS (gMG)</b>			
1. Is the request being made by or in consultation with a neurologist or other specialist in the treatment of gMG?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does the member have a diagnosis of gMG?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Does the member have a positive serologic test for anti-acetylcholine receptor (anti-AchR) antibodies?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Has the member been diagnosed with class II to IV gMG according to the Myasthenia Gravis Foundation of America?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
7. Has the member tried and failed intravenous immunoglobulin (IVIG)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
8. Will the requested therapy be used in combination with IVIG or other biologic agents for gMG treatment?	<input type="checkbox"/>	<input type="checkbox"/>	
9. If the request is for Rystiggo®, is the member's Myasthenia Gravis Activities of Daily Living (MG-ADL) score ≥ 3?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
10. If the request is for Vyvgart®, is the member's MG-ADL score ≥ 5?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
11. If the request is for Soliris® or Ultomiris®, is the member's MG-ADL score ≥ 6?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
12. If the request is for Soliris® or Ultomiris®, is the prescribing physician enrolled in Soliris® or Ultomiris® REMS program?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>REAUTHORIZATION</b>			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
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  
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## PRIOR AUTHORIZATION REQUEST FORM

### 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:**  Leqembi® (lecanemab-irmb)

Dosing/Frequency: \_\_\_\_\_

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

Questions	Yes	No	Comments/Notes
1. Is the prescribing physician a board-certified neurologist or geriatrician from an Alzheimer's Center of Excellence?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Does the member have a diagnosis of Alzheimer's disease with mild cognitive impairment or mild dementia state of disease as evidenced by ALL of the following? <ul style="list-style-type: none"> <li>• Presence of amyloid abnormalities and/or presence of amyloid beta pathology as determined by recent (within one year) Positron Emission Tomography (PET) or lumbar puncture</li> <li>• Clinical Dementia Rating-Global Score (CDR-GS) of 0.5 or 1</li> <li>• Clinical Dementia Rating (CDR) Memory Box score of 0.5 or greater</li> <li>• Mini-Mental Status Examination (MMSE) score of &gt;22</li> <li>• Objective impairment in episodic memory indicated by at least 1 standard deviation below age-adjusted mean in the Wechsler Memory Scale IV Logical Memory (subscale) II (WMS-IV LMII)</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Does documentation include a MRI of the brain within the past year without evidence of ANY the following? <ul style="list-style-type: none"> <li>• Prior cerebral hemorrhage greater than 1 cm in greatest diameter</li> <li>• Greater than 4 microhemorrhages</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

<ul style="list-style-type: none"> <li>• Superficial siderosis</li> <li>• Vasogenic edema</li> <li>• Cerebral contusion, aneurysm, vascular malformation, infective lesions, multiple lacunar infarcts or stroke involving a major vascular territory</li> <li>• Severe small vessel or white matter disease</li> </ul>			
4. Has the member had a trial and failure of BOTH cholinesterase inhibitor (e.g., donepezil, rivastigmine) and memantine?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Does the member have contraindication to amyloid testing (e.g. PET or brain MRI)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>REAUTHORIZATION</b>			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Does the member have continued evidence of mild cognitive impairment as evidenced by an updated CDR global scale score $\leq 0.5$ , RBANS delayed memory index score $\leq 85$ , and MMSE score $\geq 24$ ?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Has the member been at least 80% compliant with infusions?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>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.</b>			
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: 11/09/2023  
 Next Review Date: 11/09/2024  
 Current Effective Date: 12/01/2023

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