HEALTHY U MEDICAID

PRIOR AUTHORIZATION REQUEST FORM
CROHN'S DISEASE MEDICATIONS

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

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

- For **Medical Pharmacy** please fax requests to 801-213-1547
- For **Retail Pharmacy** requests please fax requests to: 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 855-856-5694

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

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

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

Preferred/Non-Formulary:

1. **1st Line Preferred Agents:**
   A. Infliximab products: Avsola® (infliximab-axxq), Inflectra® (infliximab-dyyb), infliximab, Remicade (infliximab), Renflexis® (infliximab-abda)
2. **2nd line preferred agents with single step; after trial and failure of 1 preferred first line agent:**
   A. Cimzia® (certolizumab), Entyvio® (vedolizumab), Humira® (adalimumab)
3. **Non-Formulary agents with a triple step; after trial and failure of 1 preferred first line agent and 2 second line agents:**
   A. Skyrizi® (risankizumab-rzaa), Stelara® (ustekinumab)

Product being requested: _____

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Is the request being made by or in consultation with a gastroenterologist?	☐	☐	
2. Does documentation include results from studies such as colonoscopy, MRI, CT scan?	☐	☐	**Please provide documentation**
3. Does the member have severe Crohn's Disease evidenced by at least one of the following: • A Crohn's Disease Activity Score (CDAI) >220 AND as shown on imaging • Active fistulizing disease	☐	☐	**Please provide documentation**

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

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Policy PHARM-HU-019
Origination Date: 01/01/2022
Reviewed/Revised Date: 09/19/2022
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