HEALTH PLANS
UNIVERSITY OF UTAH

PRIOR AUTHORIZATION REQUEST FORM

RHEUMATOID ARTHRITIS- MEDICAL INFUSED DRUGS

Actemra®, Inflectra®, Remicade®, Renflexis®, Rituxan®, Truxima®, Orencia®, Simponi Aria®

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 801-213-1547.

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: Individual Exchange: 833-981-0214, Commercial Groups: 833-981-0213, MHC: 844-262-1560

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-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 Products

1. Preferred
    a. Preferred infliximab and rituximab biosimilar product(s)- See Medical Biosimilar Products PHARM-M030
2. Non-preferred
    a. Actemra® (tocilizumab), Orencia® (abatacept), Remicade® (infliximab), Rituxan® (rituximab), Simponi® Aria (golimumab)

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, or in consultation with, a rheumatologist?	☐	☐	
2. Is the patient's condition moderate to severe based on the Disease Activity Score (DAS28) or is a tender and swollen joint count provided as well as C-reactive protein (CRP) or erythrocyte sedimentation?	☐	☐	**Please provide documentation**
3. Has the patient had an adequate trial of at least one disease modifying antirheumatic drug (e.g. methotrexate, sulfasalazine, leflunomide, hydroxychloroquine)? NOTE: If oral methotrexate is not tolerated, intramuscular or subcutaneous methotrexate must be tried.	☐	☐	**Please provide documentation**
4. Has the provider performed tuberculosis (TB) screening prior to therapy initiation?	☐	☐	**Please provide documentation**

5. If the request is for a tumor necrosis factor inhibitor, has the provider performed hepatitis B screening prior to therapy initiation?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the patient experienced at least a 20% improvement in ACR or DAS28 score since therapy initiation? If moderate or high disease activity continues > 3 months due to lack of or loss of benefit, switching agents should be evaluated.	☐	☐	**Please provide documentation**
3. Has the provider performed continued tuberculosis monitoring during therapy?	☐	☐	**Please provide documentation**
4. Has the provider performed continued Hepatitis B monitoring in HBV carriers?	☐	☐	**Please provide documentation**

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

Additional information:

Physician's Signature:

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Policy: PHARM-M024
Origination Date: 03/26/2020
Reviewed/Revised Date: 12/19/2022
Next Review Date: 12/19/2023
Current Effective Date: 01/01/2023