

PRIOR AUTHORIZATION REQUEST FORM

ULCERATIVE COLITIS- MEDICAL INFUSED DRUGS

Entyvio®, Inflectra®, Remicade®, Renflexis®

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

Dis	claimer: Prior authorization request fo	rms are subject to change in accord	dance wi	th Fede	ral and State notice requirements.		
Dat	e:	Member Name:		ID#:			
DO	B:	Gender:		Physi	cian:		
Off	ice Phone:	Office Fax:		Office	e 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 Products 1. Preferred a. Preferred infliximab biosimilar product(s)- See Medical Biosimilar Products PHARM-M030 2. Non-preferred a. Entyvio® (vedolizumab), Remicade® (infliximab) Product being requested: Dosing/Frequency: Dosing/Frequency:							
Dos	sing/Frequency:						
Dos		s for reauthorization, proceed t	o reaut	horizat	ion section		
Dos		s for reauthorization, proceed t	o reaut Yes	horizat No	ion section Comments/Notes		
Dos	If the request is	s for reauthorization, proceed t	Yes				
	If the request is	s for reauthorization, proceed to some some some some some some some som	Yes				
1.	If the request is Question Has the member been diagnosed to	s for reauthorization, proceed to the second	Yes OLITIS	No	Comments/Notes		
1.	Has the member been diagnosed of Colitis? Is the request made by, or in cons	MODERATE ULCERATIVE Consistency with moderate Ulcerative ultation with, a	Yes OLITIS	No	Comments/Notes		
1. 2. 3.	Has the member been diagnosed of Colitis? Is the request made by, or in consignation of the request made by the request made b	MODERATE ULCERATIVE Consists with moderate Ulcerative ultation with, a trial of at least one high dose unine, sulfasalazine, etc.)	Yes OLITIS	No	Comments/Notes Please provide documentation		
1. 2. 3.	Has the member been diagnosed of Colitis? Is the request made by, or in consignation gastroenterologist? Has the member had an adequate 5-aminosalicylic acid drug (mesala)	MODERATE ULCERATIVE Consistency with moderate Ulcerative for ultation with, a strial of at least one high dose simine, sulfasalazine, etc.) coulosis (TB) screening prior to sis factor inhibitor, has the	Yes OLITIS	No	Please provide documentation Please provide documentation		
1. 2. 3.	Has the member been diagnosed of Colitis? Is the request made by, or in consignation of the request made an adequate 5-aminosalicylic acid drug (mesalades). Has the provider performed tuber therapy initiation? If the request is for a tumor necrooprovider performed hepatitis B screen.	MODERATE ULCERATIVE Consistency with moderate Ulcerative for ultation with, a strial of at least one high dose simine, sulfasalazine, etc.) coulosis (TB) screening prior to sis factor inhibitor, has the	Yes OLITIS	No	Please provide documentation Please provide documentation Please provide documentation		
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2	Is the request made by, or in consultation with, a		П				
۷.	gastroenterologist?						
3.	Has the patient had more than 6 stools per day with blood OR			Please provide documentation			
	has systemic symptoms (fever, tachycardia, anemia or		ш				
	erythrocyte sedimentation rate > 30mm/h)?						
4.	Has the provider performed tuberculosis (TB) screening prior to			Please provide documentation			
	therapy initiation?		_	F			
5.	If the request is for a tumor necrosis factor inhibitor, has the			Please provide documentation			
	provider performed hepatitis B screening prior to therapy			·			
	initiation?						
FULMINANT COLITIS							
1.	Has the patient been diagnosed with fulminant colitis?						
2.	Is the request made by, or in consultation with, a						
	gastroenterologist?						
3.	Does the member more than 10 bowel movements per day with			Please provide documentation			
	continuous bleeding OR has colonic dilation, transfusion						
	requirement, or toxicity?						
4.	Has the provider performed tuberculosis (TB) screening prior to			Please provide documentation			
	therapy initiation?						
5.	If the request is for a tumor necrosis factor inhibitor, has the			Please provide documentation			
	provider performed hepatitis B screening prior to therapy						
	initiation?						
	REAUTHORIZATION						
1.	Is the request for reauthorization of therapy?						
2.	Does updated clinical documentation show a positive response			Please provide documentation			
	to therapy, such as a decrease or stabilization in the Disease						
	Activity Index (DAI) score?						
3.	Has the provider performed continued tuberculosis monitoring			Please provide documentation			
	during therapy?						
4.	Has the provider performed continued Hepatitis B monitoring in			Please provide documentation			
	HBV carriers?						
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.							
Ad	ditional information:						
Physician's Signature:							
Pny	rsician's Signature:						

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

Policy: PHARM- M025 Origination Date: 03/26/2020 Reviewed/Revised Date: 12/19/2022 Next Review Date: 12/19/2023 Current Effective Date: 01/01/2023

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