HEALTHY U CHIP

PRIOR AUTHORIZATION REQUEST FORM

RHEUMATOID ARTHRITIS

Actemra®, Avsola®, Cimzia®, Enbrel®, Hadlima™, Humira®, Inflectra®, Kevzara®, Kineret®, Olumiant®, Orencia®, 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 Healthy U CHIP Prior Authorization Department.

- For **Medical Pharmacy** please fax requests to: 801-213-1547
- 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 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:		HCPCS Code:

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

Preferred/Non-Formulary:

1. **1st Line Preferred Agents:**
   - A. Hadlima™ (adalimumab-bwwd)
   - B. Infliximab products: Avsola® (infliximab-axxq), Inflectra® (infliximab-dyyb), infliximab, Remicade (infliximab), Renflexis® (infliximab-abda)
   - C. Rituximab biosimilar products: Riabni® (rituximab-arrx), Ruxience® (rituximab-pvvr), Truxima® (rituximab-abbs)
2. **2nd line preferred agents with single step; after trial and failure of BOTH Hadlima and a preferred infliximab agent:**
   - A. Actemra® (tocilizumab), Cimzia® (certolizumab), Humira® (adalimumab), Kevzara® (sarilumab), Kineret® (anakinra), Olumiant® (baricitinb), Orencia® (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:**
   - A. 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?	☐	☐	
2. Is the requesting provider a rheumatologist or in consultation with a rheumatologist?	☐	☐	
3. Is the member's condition moderate to severe based on the Disease Activity Score (DAS28) or is a tender and swollen joint	☐	☐	**Please provide documentation**

count provided as well as C-reactive protein (CRP) or erythrocyte sedimentation rate (ESR)?			
4. Has the member 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? a. If oral methotrexate is not tolerated, intramuscular or subcutaneous methotrexate must be tried	☐	☐	**Please provide documentation**
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)?	☐	☐	**Please provide documentation**
6. If the request is for a Tumor Necrosis Factor Inhibitor or an Interleukin Receptor Antagonist, has the provider performed tuberculosis (TB) screening prior to therapy initiation?	☐	☐	**Please provide documentation**
7. If the request is for a Tumor Necrosis Factor Inhibitor, has the provider performed hepatitis B screening prior to therapy initiation?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member experienced at least a 20% improvement in ACR or DAS28 score since therapy initiation?	☐	☐	**Please provide documentation**
3. Has the provider performed continued tuberculosis monitoring during therapy?	☐	☐	**Please provide documentation**
4. Has the provider performed continued Hepatitis B monitoring in HBV carriers?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician's Signature:			

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Policy: PHARM-CHIP-065
Origination Date: 07/01/2024
Reviewed/Revised Date:
Next Review Date:
Current Effective Date: 07/01/2024