REALRx

PRIOR AUTHORIZATION REQUEST FORM

JUVENILE IDIOPATHIC ARTHRITIS MEDICATIONS

Actemra®, Enbrel®, Hadlima™, Humira®, Orencia®, Xeljanz®

For authorization, please answer each question and fax this form PLUS chart notes back to Real Rx 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/Non-Preferred:

1. Preferred
   A. Enbrel® (etanercept), Hadlima™ (adalimumab-bwwd), Humira® (adalimumab), Xeljanz® (tofacitinib)†
   †Note Xeljanz XR is not FDA approved for JIA
2. Non-Preferred after trial and failure of two preferred first line agents:
   A. Actema® (tocilizumab), Orencia® (abatacept)

Product being requested: _____

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Is the requested medication being purchased by the provider's office and to be billed under the medical benefit ('buy-and-bill')?	☐	☐	
2. Is this request for an **expedited** review? By checking the **"Yes"** box to request an expedited review (24 hours), you are certifying that applying the standard review time frame (72 hours) may place the member's life, health, or ability to regain maximum function in serious jeopardy.	☐	☐	
3. Does the member have a documented diagnosis of Juvenile Idiopathic Arthritis?	☐	☐	**Please provide documentation**
4. Is the requesting prescriber a rheumatologist or working in consultation with a rheumatologist?	☐	☐	
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 or Orencia®, has the provider performed hepatitis B screening prior to therapy initiation?	☐	☐	**Please provide documentation**
7. If the request is for Xeljanz, does documentation show an inadequate response or intolerance to at least one TNF (tumor necrosis factor) blocker such as an infliximab product, Cimzia, Enbrel, Humira and/or Simponi AND does documentation show the member will not be receiving Xeljanz in combination with a potent immunosuppressant (e.g., azathioprine or cyclosporine)?	☐	☐	**Please provide documentation**
ACTIVE JOINT COUNT ≤ 4 WITHOUT SYSTEMIC FEATURES			
1. Does the member have an active joint count of **≤ 4** *without* systemic features?	☐	☐	**Please provide documentation**
2. Has the member had an adequate trial of, or intolerance/contraindication to, a nonsteroidal anti-inflammatory drug (NSAID)?	☐	☐	**Please provide documentation**
3. Has the member had an adequate trial of, or intolerance/contraindication to, methotrexate or leflunomide?	☐	☐	**Please provide documentation**
4. Is the request for a preferred product (Enbrel®, Hadlima™, Humira®, Xeljanz®)?	☐	☐	
ACTIVE JOINT COUNT > 4 WITHOUT SYSTEMIC FEATURES			
1. Does the member have an active joint count of **> 4** *without* systemic features?	☐	☐	**Please provide documentation**
2. Has the member had a 3-month trial of, or intolerance/contraindication to, methotrexate or leflunomide?	☐	☐	**Please provide documentation**
MILD TO MODERATE ACUTE DISEASE WITH SYSTEMIC FEATURES			
1. Does the member have mild to moderate acute disease with systemic features of nondisabling symptoms without evidence of macrophage activation syndrome?	☐	☐	**Please provide documentation**
2. Has the member had an adequate trial of, or intolerance/contraindication to, a nonsteroidal anti-inflammatory drug (NSAID)?	☐	☐	**Please provide documentation**
MODERATE TO SEVERE ACUTE DISEASE WITH SYSTEMIC FEATURES			
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?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member's therapy been re-evaluated within the past 12 months?	☐	☐	
3. Has the therapy shown to be tolerable and effective with a decrease or stabilization in disease severity?	☐	☐	**Please provide documentation**
4. Does the member show a continued medical need for the therapy?	☐	☐	**Please provide documentation**
5. Has the provider performed continued tuberculosis monitoring during therapy?	☐	☐	**Please provide documentation**
6. 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-041
Origination Date: 04/04/2018
Reviewed/Revised Date: 09/13/2023
Next Review Date: 09/13/2024
Current Effective Date: 10/01/2023