MEDICAL PHARMACY PRIOR AUTHORIZATION REQUEST FORM

JUVENILE IDIOPATHIC ARTHRITIS- MEDICAL INFUSED DRUGS

Avsola®, Inflectra®, Orencia®, Remicade®, Renflexis®, Tyenne®

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

- Healthy U CHIP: 801-213-1547

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.

- Healthy U CHIP: 833-404-4300

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. 1st Line Preferred agents:
   a. Avsola® (infliximab-axxq), Inflectra® (infliximab-dyyb), infliximab, Remicade® (infliximab), Renflexis® (infliximab-abda)
   b. Tyenne® (tocilizumab)
   c. Orencia® (abatacept)
2. Non-Preferred agents:
   a. N/A

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. Does the member have moderate to severe Juvenile Idiopathic Arthritis?	☐	☐	
3. Has the provider performed tuberculosis (TB) screening prior to therapy initiation?	☐	☐	
4. Has the provider performed hepatitis screening prior to therapy initiation?	☐	☐	
1. Has the member had an adequate 3-month trial of a nonsteroidal anti-inflammatory drug (NSAID)?	☐	☐	**Please provide documentation**

2. Has the member had an adequate 3-month trial of methotrexate or leflunomide?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does updated documentation show that the member has a continued medical need and that the therapy is tolerable and effective?	☐	☐	**Please provide documentation**
3. Has the provider performed continued tuberculosis monitoring during therapy?	☐	☐	
4. Has the provider performed continued Hepatitis B monitoring in 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.

Additional information:

PRESCRIBER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

Physician's Signature:	Date:

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Policy: PHARM-CHIP-M021
Origination Date: 01/01/2026
Reviewed/Revised Date:
Next Review Date:
Current Effective Date: 01/01/2026

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