HEALTHY U MEDICAID

PRIOR AUTHORIZATION REQUEST FORM

JUVENILE IDIOPATHIC ARTHRITIS MEDICATIONS

Actemra®, Avsola® Enbrel®, Hadlima™, Humira®, Inflectra®, infliximab, Orencia®, Remicade®, Renflexis®, Xeljanz/XR®

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U 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 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-dwwb)
   B. Infliximab products: [Avsola® (infliximab-axxq), Inflectra® (infliximab-dyyb), infliximab, Remicade (infliximab), Renflexis® (infliximab-abda)], Actemra® (tocilizumab), Orencia® (abatacept)
2. **2nd line preferred agents with single step; after trial and failure of BOTH Hadlima and a preferred infliximab agent:**
   A. Humira® (adalimumab), Xeljanz®/Xeljanz XR® (tofacitinib)
3. **Non-Formulary Brands with a triple step; after trial and failure of BOTH Hadlima and a preferred infliximab agent and 2 second line agents:**
   A. Enbrel® (etanercept)

Product being requested: _____

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Does the member have a documented diagnosis of Juvenile Idiopathic Arthritis?	☐	☐	**Please provide documentation**
2. Is the requesting prescriber a rheumatologist or working in consultation with a rheumatologist?	☐	☐	
3. Has the provider performed tuberculosis (TB) screening prior to therapy initiation?	☐	☐	**Please provide documentation**

4. 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**
5. If the request is for Xejanz/XR, does documentation show an inadequate response or intolerance to at least one tumor necrosis factor (TNF) blocker such as an infliximab product, Cimzia, Humira and/or Simponi AND does documentation show the member will not be receiving Xeljanz/XR 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 the preferred product, Humira®?	☐	☐	
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**
SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (JIA)			
1. Does the member have mild to moderate systemic JIA?	☐	☐	**Please provide documentation**
2. Has the member had an adequate trial of NSAIDs?	☐	☐	
3. Does the member have moderate to severe systemic JIA?	☐	☐	**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:

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

Policy PHARM-HU-041
Origination Date: 01/01/2022
Reviewed/Revised Date: 09/13/2023
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