HEALTHY U MEDICAID

# PRIOR AUTHORIZATION REQUEST FORM

## PSORIATIC ARTHRITIS

Avsola®, Cimzia®, Cosentyx®, Enbrel®, Hadlima™, Humira®, Inflectra®, infliximab, Orencia®, Otezla®, Remicade®, Renflexis®, Rinvoq®, Simponi®, Stelara®, Skyrizi®, Taltz®, Tremfya®, 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-bwwd)
   B. Infliximab products: Avsola® (infliximab-axxq), Inflectra® (infliximab-dyyb), infliximab, Remicade (infliximab), Renflexis® (infliximab-abda)
2. **2nd line preferred agents with single step; after trial and failure of BOTH Hadlima and a preferred infliximab agent:**
   A. Cimzia® (certolizumab), Humira® (adalimumab), Orencia® (abatacept), Otezla® (apremilast), Taltz® (ixekizumab), 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. Cosentyx® (secukinumab), Enbrel® (etanercept), Rinvoq® (upadacitinib), Skyrizi® (risankizumab-rzaa) Simponi® (golimumab), Stelara® (ustekinumab), Tremfya® (guselkumab)

**Product being requested:** _____

Dosing/Frequency:_____

**If the request is for reauthorization, proceed to reauthorization section**

| Questions | Yes | No | Comments/Notes |
|---|---|---|---|
| 1. Is the patient 18 years of age or older with active psoriatic arthritis? | ☐ | ☐ | **Please provide documentation** |
| 2. Is the request from, or in consultation with, a rheumatologist or a dermatologist? | ☐ | ☐ | |
| 3. Has the patient had an adequate trial and failure of at least one of the following disease-modifying antirheumatic drugs | ☐ | ☐ | **Please provide documentation** |

| | | | |
|---|---|---|---|
| (DMARDs), unless contraindicated to all: methotrexate, leflunomide, sulfasalazine, azathioprine, intra-articular glucocorticoid injections, hydroxychloroquine, D-penicillamine, or minocycline? | | | |
| 4. Does the member have moderate axial disease, severe disease, or enthesitis?<br>• For patients with moderate axial disease, severe disease, or enthesitis, a trial and failure of a DMARD may not be necessary. | ☐ | ☐ | **Please provide documentation** |
| 5. If the request is for Xeljanz/XR®, does documentation show inadequate response or intolerance to at least one TNF (tumor necrosis factor) blocker such as an infliximab, 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** |
| 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's therapy been re-evaluated within the past 12 months? | ☐ | ☐ | |
| 3. Has the therapy shown to be tolerable and effective with a significant decrease 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-HU-062
Origination Date: 01/01/2022
Reviewed/Revised Date: 09/13/2023
Next Review Date: 09/13/2024
Current Effective Date: 10/01/2023