HEALTHY U MEDICAID

PRIOR AUTHORIZATION REQUEST FORM

ULCERATIVE COLITIS

Avsola®, Entyvio®, Hadlima™, Humira®, Inflectra®, infliximab, Remicade®, Renflexis®, Rinvoq®, Simponi®, Stelara®, Xeljanz®

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-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. Enytvio® (vedolizumab) IV, Humira® (adalimumab), 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. Rinvoq® (upadacitinib), Simponi® (golimumab), Stelara® (ustekinumab)
4. **Non-Formulary Agent after trial and failure of all the above:**
   - A. Entyvio® (vedolizumab) subcutaneous injection

Product being requested: _____

Dosing/Frequency: _____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
MODERATE TO SEVERE ULCERATIVE COLITIS			
1. Has the member been diagnosed with moderate to severe Ulcerative Colitis?	☐	☐	**Please provide documentation**
2. Is the prescribing provider a gastroenterologist or in consultation with a gastroenterologist?	☐	☐	

3. Has the provider performed tuberculosis (TB) screening prior to therapy initiation?	☐	☐	**Please provide documentation**
4. If the request is for Tumor Necrosis Factor Inhibitors (TNFIs), Rinvoq or Xeljanz/XR, has the provider performed hepatitis B screening prior to therapy initiation?	☐	☐	**Please provide documentation**
5. Has the member had an adequate trial and failure of at least one of the following, or contraindication to all: • High dose oral 5-aminosalicyclic acid drug • Topical 5-aminosalicylic acid drug	☐	☐	**Please provide documentation**
6. If the request is for Rinvoq or Xeljanz/XR®, does documentation show 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 Rinvoq or Xeljanz/XR in combination with a potent immunosuppressant (e.g., azathioprine or cyclosporine)?	☐	☐	**Please provide documentation**
SEVERE ULCERATIVE COLITIS			
1. Has the member been diagnosed with severe Ulcerative Colitis? • Has the patient had more than six stools per day with blood OR has systemic symptoms (fever, tachycardia, anemia or erythrocyte sedimentation rate > 30mm/h)?	☐	☐	**Please provide documentation**
2. Is the prescribing provider a gastroenterologist or in consultation with a gastroenterologist?	☐	☐	**Please provide documentation**
3. Has the provider performed tuberculosis (TB) screening prior to therapy initiation?	☐	☐	**Please provide documentation**
4. Has the provider performed hepatitis B screening prior to therapy initiation?	☐	☐	**Please provide documentation**
5. If the request is for Rinvoq or Xeljanz/XR®, does documentation show 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 Rinvoq or Xeljanz/XR in combination with a potent immunosuppressant (e.g., azathioprine or cyclosporine)?	☐	☐	**Please provide documentation**
FULMINANT COLITIS			
1. Has the member been diagnosed with fulminant colitis? • Has the member had more than 10 bowel movements per day with continuous bleeding OR has colonic dilation, transfusion requirement, or toxicity?	☐	☐	**Please provide documentation**
2. Is the prescribing provider a gastroenterologist or in consultation with a gastroenterologist?	☐	☐	**Please provide documentation**
3. Has the provider performed tuberculosis (TB) screening prior to therapy initiation?	☐	☐	**Please provide documentation**
4. Has the provider performed hepatitis B screening prior to therapy initiation?	☐	☐	**Please provide documentation**
5. If the request is for Rinvoq or Xeljanz/XR®, does documentation show 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 Rinvoq or Xeljanz/XR in combination with a potent immunosuppressant (e.g., azathioprine or cyclosporine)?	☐	☐	**Please provide documentation**

REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does updated clinical documentation show a positive response to therapy, such as a decrease or stabilization in the Disease Activity Index (DAI) score?	☐	☐	**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:			

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

Policy: PHARM-HU-075
Origination Date: 01/01/2022
Reviewed/Revised Date: 05/22/2024
Next Review Date: 05/22/2025
Current Effective Date: 06/01/2024