

PRIOR AUTHORIZATION REQUEST FORM

Non-Preferred Immunomodulators

Arcalyst, Bimzelx, Cimzia, Cosentyx, Entyvio, Ilaris, Ilumya, Kevzara, Kineret, Leqselvi, Litfulo, Nemluvio, Olumiant, Omvoh, Orencia, Otezla pak, Simponi, Skyrizi, Sotyktu, Spevigo, Tremfya, Velsipity

For authorization, please answer each question and fax this form PLUS chart notes back to RealRx Medicaid Prior Authorization Department 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 Pharmacy Customer Service for assistance.

- Healthy U: 855-856-5694
- Healthy U CHIP: 855-203-3633
- Health Choice Utah: 855-864-1404

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:

Preferred: Cyltezo 40 mg/0.8 ml+, Enbrel+, Hadlima 40 mg/0.8 ml+, Humira+, Otezla+, Pyzchiva+, Rinvoq+, Rinvoq LQ+, Simlandi+, Steqeyma+, Taltz+, Tyenne+, Xeljanz+, Xeljanz XR+

Non-preferred: other adalimumab biosimilars+, Arcalyst, Bimzelx, Cimzia, Cosentyx, Entyvio SubQ, Humira high concentration Kit+, Ilaris, Ilumya, Kevzara, Kineret, Leqselvi, Litfulo, Olumiant, Omvoh, Orencia, Otezla pak, Simponi, Skyrizi, Sotyktu, Spevigo, tocilizumab (reference product and other biosimilars)+, Tremfya, ustekinumab (reference product and other biosimilars)+, Velsipity

+see drug specific prior authorization forms

Note: IV formulations are covered under the medical benefit.

Product Requested: _____

Directions for Use: _____

Criteria for Approval: (All of the following criteria must be met)	Yes	No
1. Does the patient have a documented diagnosis of a condition listed on the medication's FDA-approved label? Condition: _____ <input type="checkbox"/> Other confirmation testing, if applicable	<input type="checkbox"/>	<input type="checkbox"/>
2. Is the medication being prescribed by or in consultation with a provider specializing in the disease treatment?	<input type="checkbox"/>	<input type="checkbox"/>
3. Does the use of medication follow FDA-approved label use instructions (including age, dose, monitoring for boxed warnings and contraindications)?	<input type="checkbox"/>	<input type="checkbox"/>
4. Has the provider submitted documentation of appropriate first-line treatments or interventions, if current treatment standards recommend other treatment(s) prior to use of the requested drug? Medication: _____ Date of therapy: _____	<input type="checkbox"/>	<input type="checkbox"/>

Details of Failure: _____		
5. Has the patient tried and failed at least TWO preferred products in the immunomodulator therapeutic class for a minimum of three months or has the prescriber demonstrated medical necessity for a non-preferred product, if applicable? Medication(1): _____ Date of therapy: _____ Details of Failure: _____ Medication(2): _____ Date of therapy: _____ Details of Failure: _____	<input type="checkbox"/>	<input type="checkbox"/>
6. Does the provider attest that the patient is not on concurrent treatment or that the medication will not be used in combination with other TNF-inhibitor, biologic response modifier or other biologic DMARDs, Janus kinase Inhibitors, or Phosphodiesterase 4 inhibitor (i.e., apremilast, tofacitinib, baricitinib) as verified by prescriber attestation, patient's medication history, or submitted documentation?	<input type="checkbox"/>	<input type="checkbox"/>
Other - Off Label or Compendia Use of FDA-Approved Drugs Additional Criterion:		
1. Does the clinical documentation show an adequate trial and failure with at least ONE FDA-labeled and Medicaid preferred medication, if applicable?	<input type="checkbox"/>	<input type="checkbox"/>
2. Provider attest the requested drug is being used for a medically accepted indication that is supported by information from the appropriate compendia* of current literature. Including at least (1) major multi-site study or three (3) smaller studies published in JAMA, NEJM, Lancet, or other peer review specialty medical journals in the most recent years? * Compendia use must be recommended by generally accepted compendia such as American Hospital Formulary Service Drug Information (AHFS), United States Pharmacopeia-Drug Information(USP-DI),the Micromedex Information System, Pediatric and Neonatal Lexi-Drugs, or clinical guidelines.	<input type="checkbox"/>	<input type="checkbox"/>
Reauthorization		
1. Has the provider submitted an updated letter with medical justification and updated chart notes demonstrating positive clinical response?	<input type="checkbox"/>	<input type="checkbox"/>
PRESCRIBER CERTIFICATION		
I hereby certify this treatment is indicated, necessary and meets the guidelines for use.		
Physician's Signature:	Date:	

Initial Authorization: Up to six (6) months

Reauthorization: Up to one (1) year

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

Note:

- The patient must have regular appointments to receive or follow up on the medication in the provider's office. The patient must remain in the office for an adequate amount of time to allow for observation and treatment of anaphylaxis, if necessary. If/when any change of dose is requested, the prescriber must indicate, in writing, the reasoning for the dose increase.

Policy: PHARM-HYB-181

Origination Date: 01/01/2026

Reviewed/Revised Date:

Next Review Date:

Current Effective Date: 01/01/2026

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