HEALTH PLANS
UNIVERSITY OF UTAH

PRIOR AUTHORIZATION REQUEST FORM

CROHN'S DISEASE- MEDICAL INFUSED DRUGS

Entyvio®, Inflectra®, Remicade®, Renflexis®, Tysabri®

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 801-213-1547.

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

If you have medical pharmacy prior authorization questions, please call for assistance: Individual Exchange: 833-981-0214, Commercial Groups: 833-981-0213, MHC: 844-262-1560

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 Products

1. Preferred
    a. Preferred infliximab biosimilar product(s)- See Medical Biosimilar Products PHARM-M030
2. Non-preferred:
    a. Entyvio® (vedolizumab), Remicade® (infliximab), Tysabri® (natalizumab)

Product being requested: _____

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Is the request being made by, or in consultation with, a gastroenterologist?	☐	☐	
2. Does documentation include results from studies such as colonoscopy, MRI, CT scan?	☐	☐	**Please provide documentation**
3. Does the member have severe Crohn's Disease evidenced by at least one of the following: • A Crohn's Disease Activity Score (CDAI) >220 AND as shown on imaging • Active fistulizing disease	☐	☐	**Please provide documentation**

4. Does the member have moderate to severe Crohn's Disease evidenced by the following: • Persistent fistulizing disease or active ulcerative disease (CDAI > 150 or via endoscopic assessment) despite an adequate trial with a Disease Modifying Anti-rheumatic Drug (DMARD) such as methotrexate, azathioprine or 6-mercaptopurine, unless contraindicated to all.	☐	☐	**Please provide documentation**
5. Has the provider performed tuberculosis (TB) screening prior to therapy initiation? • Not required if request is for Tysabri	☐	☐	**Please provide documentation**
6. 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. Does documentation show a stabilization or decrease in the CDAI score of at least 70 points compared to baseline, endoscopic improvement in mucosa and/or no new fistulizing disease information?	☐	☐	**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 Signature:			

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Policy: PHARM- M019
Origination Date: 03/26/2020
Reviewed/Revised Date: 12/19/2022
Next Review Date: 12/19/2023
Current Effective Date: 01/01/2023