

**PRIOR AUTHORIZATION REQUEST FORM**  
**JUVENILE IDIOPATHIC ARTHRITIS- MEDICAL INFUSED DRUGS**

Inflectra®, Orenzia®, Remicade®, Renflexis®

**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. Orenzia® (abatacept), Remicade® (infliximab)

**Product being requested:** \_\_\_\_\_

**Dosing/Frequency:** \_\_\_\_\_

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

Questions	Yes	No	Comments/Notes
1. Is the requesting made by, or in consultation with, a rheumatologist?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the provider performed tuberculosis (TB) screening prior to therapy initiation?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Has the provider performed hepatitis screening prior to therapy initiation?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

**ACTIVE JOINT COUNT ≤ 4 WITHOUT SYSTEMIC FEATURES**

1. Does the member have an active joint count of ≤ 4 without systemic features?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Has the member had an adequate trial of a nonsteroidal anti-inflammatory drug (NSAID)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Has the member had an adequate trial of methotrexate or leflunomide?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

ACTIVE JOINT COUNT > 4 WITHOUT SYSTEMIC FEATURES			
1. Does the member have an active joint count of > 4 <i>without</i> systemic features?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
2. Has the member had an adequate trial of methotrexate or leflunomide?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (JIA)			
1. Does the member have mild to moderate systemic JIA?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
2. Has the member had an adequate trial of NSAIDs?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Does the member have moderate to severe systemic JIA?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member's therapy been re-evaluated within the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Has the therapy shown to be tolerable and effective with a decrease or stabilization in disease severity?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Does the member show a continued medical need for the therapy?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
5. Has the provider performed continued tuberculosis monitoring during therapy?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
6. Has the provider performed continued Hepatitis B monitoring in HBV carriers?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
<b>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.</b>			
Additional information:			
Physician's Signature:			

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

Policy: PHARM- M021  
 Origination Date: 03/26/2020  
 Reviewed/Revised Date: 12/19/2022  
 Next Review Date: 12/19/2023  
 Current Effective Date: 01/01/2023

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