HEALTH PLANS
UNIVERSITY OF UTAH

PRIOR AUTHORIZATION REQUEST FORM

PSORIATIC ARTHRITIS- MEDICAL INFUSED DRUGS

Inflectra®, Orencia®, Remicade®, Renflexis®, Simponi Aria®

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. Orencia® (abatacept), Remicade® (infliximab), Simponi®(golimumab)

Product being requested: _____

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Is the request made by, or in consultation, with a rheumatologist or dermatologist?	☐	☐	
2. Has the member had an adequate trial of at least one disease-modifying antirheumatic drug (DMARD) such as methotrexate, leflunomide, sulfasalazine, azathioprine, intra-articular glucocorticoid injections, hydroxychloroquine, D-penicillamine, minocycline?	☐	☐	**Please provide documentation**
3. Does the member have moderate axial disease, severe disease, or enthesitis?	☐	☐	**Please provide documentation**
4. Has the provider performed tuberculosis (TB) and hepatitis B screenings 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 6 months?	☐	☐	
3. Has the therapy shown to be tolerable and effective with an improvement in condition?	☐	☐	**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 Signature:			

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Policy: PHARM- M023
Origination Date: 03/26/2020
Reviewed/Revised Date: 12/19/2022
Next Review Date: 12/19/2023
Current Effective Date: 01/01/2023