HEALTH PLANS
UNIVERSITY OF UTAH

PRIOR AUTHORIZATION REQUEST FORM

ULCERATIVE COLITIS- MEDICAL INFUSED DRUGS

Entyvio®, Inflectra®, 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. Entyvio® (vedolizumab), Remicade® (infliximab)

Product being requested: _____

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
MODERATE ULCERATIVE COLITIS			
1. Has the member been diagnosed with moderate Ulcerative Colitis?	☐	☐	**Please provide documentation**
2. Is the request made by, or in consultation with, a gastroenterologist?	☐	☐	
3. Has the member had an adequate trial of at least one high dose 5-aminosalicylic acid drug (mesalamine, sulfasalazine, etc.)	☐	☐	**Please provide documentation**
4. Has the provider performed tuberculosis (TB) screening prior to therapy initiation?	☐	☐	**Please provide documentation**
5. If the request is for a tumor necrosis factor inhibitor, has the provider performed hepatitis B screening prior to therapy initiation?	☐	☐	**Please provide documentation**
SEVERE ULCERATIVE COLITIS			
1. Has the patient been diagnosed with severe Ulcerative Colitis?	☐	☐	**Please provide documentation**

2. Is the request made by, or in consultation with, a gastroenterologist?	☐	☐	
3. Has the patient had more than 6 stools per day with blood OR has systemic symptoms (fever, tachycardia, anemia or erythrocyte sedimentation rate > 30mm/h)?	☐	☐	**Please provide documentation**
4. Has the provider performed tuberculosis (TB) screening prior to therapy initiation?	☐	☐	**Please provide documentation**
5. If the request is for a tumor necrosis factor inhibitor, has the provider performed hepatitis B screening prior to therapy initiation?	☐	☐	**Please provide documentation**
FULMINANT COLITIS			
1. Has the patient been diagnosed with fulminant colitis?	☐	☐	
2. Is the request made by, or in consultation with, a gastroenterologist?	☐	☐	
3. Does the member more than 10 bowel movements per day with continuous bleeding OR has colonic dilation, transfusion requirement, or toxicity?	☐	☐	**Please provide documentation**
4. Has the provider performed tuberculosis (TB) screening prior to therapy initiation?	☐	☐	**Please provide documentation**
5. 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 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- M025
Origination Date: 03/26/2020
Reviewed/Revised Date: 12/19/2022
Next Review Date: 12/19/2023
Current Effective Date: 01/01/2023