HEALTH PLANS
UNIVERSITY OF UTAH

PRIOR AUTHORIZATION REQUEST FORM

# Non-Radiographic Axial Spondyloarthritis (nrx-SpA)- Medical Infused Drugs

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 888-509-8142.**

**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: | | |

***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. 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 member 18 years of age or older with Non-Radiographic Axial Spondyloarthritis? | ☐ | ☐ | **Please provide documentation** |
| 2. Is the requesting provider a rheumatologist or in consultation with one? | ☐ | ☐ | |
| 3. Does documentation show an adequate trial and failure of at least one prescription strength nonsteroidal anti-inflammatory drug (NSAID) at the maximally tolerated dose, unless contraindicated? | ☐ | ☐ | **Please provide documentation** |
| 4. Has the provider performed tuberculosis (TB) screening prior to therapy initiation? | ☐ | ☐ | **Please provide documentation** |
| 5. For tumor necrosis factor inhibitors (TNFIs), has the provider preformed Hepatitis B screening prior to therapy initiation? | ☐ | ☐ | **Please provide documentation** |
| **REAUTHORIZATION** | | | |
| 1. Is the request for reauthorization of therapy? | ☐ | ☐ | |

| | | | |
|---|---|---|---|
| 2. Does updated documentation show that the member has a continued medical need? | ☐ | ☐ | **Please provide documentation** |
| 3. Has the provider performed continued tuberculosis screening 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:

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

Policy: PHARM-M041
Origination Date: 08/05/2022
Reviewed/Revised Date: 12/19/2022
Next Review Date: 12/19/2023
Current Effective Date: 01/01/2023