

PRIOR AUTHORIZATION REQUEST FORM

ANKYLOSING SPONDYLITIS

Cimzia®, Cosentyx®, Enbrel®, Humira®, Simponi®, Taltz®

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 delay and/or denial of the request.

If you have prior authorization questions, please call for assistance: Healthy U: 855-856-5694, University of Utah Health Employees: 855-856-5690, Individual & Family Plans : 855-869-4769, Commercial Groups: 855-859-4892, MHC 855-885-7695

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

1. Preferred Brands:
 - A. Cimzia® (certolizumab), Humira® (adalimumab), Simponi® (golimumab)
2. Non-Preferred Brands with a single step; after trial and failure of at least 1 first line agent:
 - A. Taltz® (ixekizumab)
3. Non-Preferred Brands with a triple step; after trial and failure of at least 2 preferred agents AND Taltz® (ixekizumab):
 - A. Cosentyx® (secukinumab), Enbrel® (etanercept)

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 Ankylosing Spondylitis?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
2. Is the requesting provider a rheumatologist or in consultation with one?	<input type="checkbox"/>	<input type="checkbox"/>	
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?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Has the provider performed tuberculosis (TB) screening prior to therapy initiation?	<input type="checkbox"/>	<input type="checkbox"/>	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?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation

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REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does updated documentation show that the member has a continued medical need?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
3. Does updated documentation show the member responded to therapy, such as a decrease in disease severity or disease stabilization in the Bath Ankylosing Spondylitis Disease Activity Index (BASAI) or the Ankylosing Spondylitis Disease Activity Score (ASDAS)?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Has the provider performed continued tuberculosis screening during therapy?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
5. Has the provider performed continued Hepatitis B monitoring in HBV carriers?	<input type="checkbox"/>	<input type="checkbox"/>	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 delay and/or denial of the request****

Policy PHARM- 003
 Origination Date: 03/30/2018
 Reviewed/Revised Date: 01/27/2021
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