HEALTH PLANS
UNIVERSITY OF UTAH

PRIOR AUTHORIZATION REQUEST FORM
CROHN'S DISEASE MEDICATIONS
Cimzia®, Humira®, Stelara®

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), Stelara® (ustekinumab)

Product being requested: _____

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Is the request being made by or in consultation with a gastroenterologist?	☐	☐	
2. Does the member have moderate to severe Crohn's Disease and meet at least one of the following: • A Crohn's Disease Activity Score (CDAI) >220 • Active fistulizing disease despite corticosteroid therapy • Recurrent fistulizing disease when corticosteroids are tapered • Persistent fistulizing disease or active ulcerative disease despite an adequate trial with a Disease Modifying Anti-rheumatic Drug (DMARD) such as methotrexate, azathioprine or 6-mercaptopurine, unless contraindicated to all.	☐	☐	**Please provide documentation**
3. Has the provider performed tuberculosis (TB) screening prior to therapy initiation?	☐	☐	**Please provide documentation**

4. 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 documentation show a stabilization or decrease in the CDAI score of at least 70 points compared to baseline, endoscopic improvement in mucosa and/or no new fistulizing disease information?	☐	☐	**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 Signature:

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Policy PHARM-019
Origination Date: 03/14/2018
Reviewed/Revised Date: 01/27/2021
Next Review Date: 01/27/2022
Current Effective Date: 02/01/2021