

**PRIOR AUTHORIZATION REQUEST FORM
 JUVENILE IDIOPATHIC ARTHRITIS MEDICATIONS**

Actemra[®], Enbrel[®], Humira[®], Orenzia[®], Xeljanz[®]

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:
 - A. Humira[®] (adalimumab)
2. Non-Preferred with a single step; after trial and failure of Humira[®] (adalimumab):
 - A. Actemra[®] (tocilizumab), Orenzia[®] (abatacept), Xeljanz[®]/Xeljanz XR[®] (tofacitinib)
3. Non-Preferred with a triple step; after trial and failure of Humira[®] (adalimumab), Actema[®] (tocilizumab), and Orenzia[®] (abatacept):
 - A. Enbrel[®] (etanercept)

Product being requested: _____

Dosing/Frequency: _____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Does the member have a documented diagnosis of Juvenile Idiopathic Arthritis?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
2. Is the requesting prescriber a rheumatologist or working in consultation with a rheumatologist?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Has the provider performed tuberculosis (TB) screening prior to therapy initiation?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. If the request is for a Tumor Necrosis Factor Inhibitor or Orenzia [®] , has the provider performed hepatitis B screening prior to therapy initiation?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation

ACTIVE JOINT COUNT ≤ 4 WITHOUT SYSTEMIC FEATURES

1. Does the member have an active joint count of ≤ 4 <i>without</i> systemic features?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
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2. Has the member had an adequate trial of, or intolerance/contraindication to, a nonsteroidal anti-inflammatory drug (NSAID)?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
3. Has the member had an adequate trial of, or intolerance/contraindication to, methotrexate or leflunomide?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Is the request for the preferred product, Humira®?	<input type="checkbox"/>	<input type="checkbox"/>	
ACTIVE JOINT COUNT > 4 WITHOUT SYSTEMIC FEATURES			
1. Does the member have an active joint count of > 4 <i>without</i> systemic features?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
2. Has the member had a 3-month trial of, or intolerance/contraindication to, methotrexate or leflunomide?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
MILD TO MODERATE ACUTE DISEASE WITH SYSTEMIC FEATURES			
1. Does the member have mild to moderate acute disease with systemic features of nondisabling symptoms without evidence of macrophage activation syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
2. Has the member had an adequate trial of, or intolerance/contraindication to, a nonsteroidal anti-inflammatory drug (NSAID)?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
MODERATE TO SEVERE ACUTE DISEASE WITH SYSTEMIC FEATURES			
1. Has the member shown systemic symptoms such as high fevers with poor response to NSAIDs, other serious systemic manifestations including serositis and possible early macrophage activation syndrome, and/or moderate-to-severe polyarthritis?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member's therapy been re-evaluated within the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Has the therapy shown to be tolerable and effective with a decrease or stabilization in disease severity?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Does the member show a continued medical need for the therapy?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
5. Has the provider performed continued tuberculosis monitoring during therapy?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
6. 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:			

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Physician's Signature:

****Failure to submit clinical documentation to support this request will result in delay and/or denial of the request****

Policy PHARM- 041
Origination Date: 04/04/2018
Reviewed/Revised Date: 03/24/2021
Next Review Date: 03/24/2022
Current Effective Date: 04/01/2021

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