HEALTH PLANS
UNIVERSITY OF UTAH

PRIOR AUTHORIZATION REQUEST FORM

PSORIATIC ARTHRITIS

Cimzia®, Cosentyx®, Enbrel®, Humira®, Orencia®, Otezla®, Simponi®, Stelara®, Taltz®, Tremfya®, Xeljanz/XR®

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 Agents:
    - A. Preferred:
        - i. Cimzia® (certolizumab), Humira® (adalimumab), Otezla® (apremilast), Simponi® (golimumab), Stelara® (ustekinumab), Tremfya® (guselkumab)
    - B. Preferred with a double step; after trial and failure of at least 2 first line agents with the exception of Otezla® (apremilast):
        - i. Xeljanz/XR ® (tofacitinib)
2. Non-preferred:
    - A. Non-Preferred with a single step after trial and failure of at least 1 first line agents agent with the exception of Otezla® (apremilast):
        - i. Taltz® (ixekizumab)
    - B. Non-Preferred with a double step; after trial and failure of at least 2 first line agents agent with the exception of Otezla® (apremilast):
        - i. Orencia® (abatacept)
    - C. Non-Preferred with a 4 step requirement; after trial and failure of at least 2 first line agents agent with the exception of Otezla® (apremilast) PLUS 2 of Orencia® (abatacept), Taltz® (ixekizumab) or Xeljanz/XR ® (tofacitinib)
        - i. Enbrel® (etanercept)
    - D. Non-Preferred with a 4 step requirement; after trial and failure of at least 2 first line agents agent with the exception of Otezla® (apremilast) PLUS Taltz® (ixekizumab) AND Orencia® (abatacept) OR Xeljanz® (tofacitinib):
        - i. Cosentyx® (secukinumab)

Product being requested: _____

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section			
Questions	**Yes**	**No**	**Comments/Notes**
1. Is the patient 18 years of age or older with active psoriatic arthritis?	☐	☐	**Please provide documentation**
2. Is the request from, or in consultation with, a rheumatologist or a dermatologist?	☐	☐	
3. Has the patient had an adequate trial and failure of at least one of the following disease-modifying antirheumatic drugs (DMARDs), unless contraindicated to all: methotrexate, leflunomide, sulfasalazine, azathioprine, intra-articular glucocorticoid injections, hydroxychloroquine, D-penicillamine, or minocycline?	☐	☐	**Please provide documentation**
4. Does the member have moderate axial disease, severe disease, or enthesitis? • For patients with moderate axial disease, severe disease, or enthesitis, a trial and failure of a DMARD may not be necessary.	☐	☐	**Please provide documentation**
5. If the request is for a Tumor Necrosis Factor Inhibitor or an Interleukin Receptor Antagonist, has the provider performed tuberculosis (TB) screening prior to therapy initiation?	☐	☐	**Please provide documentation**
6. 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. Has the member's therapy been re-evaluated within the past 12 months?	☐	☐	
3. Has the therapy shown to be tolerable and effective with a significant decrease in disease severity?	☐	☐	**Please provide documentation**
4. Does the member show a continued medical need for the therapy?	☐	☐	**Please provide documentation**
5. Has the provider performed continued tuberculosis monitoring during therapy?	☐	☐	**Please provide documentation**
1. 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:

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Policy PHARM- 062
Origination Date: 03/27/2018
Reviewed/Revised Date: 01/27/2021
Next Review Date: 01/27/2022
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