HEALTH PLANS
UNIVERSITY OF UTAH

PRIOR AUTHORIZATION REQUEST FORM
ULCERATIVE COLITIS
Humira®, Simponi®, Stelara®, 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 Brand:
   A. Humira® (adalimumab), Simponi® (golimumab), Stelara® (ustekinumab)
2. Preferred Brand with a double step; after trial and failure of BOTH first line agents:
   A. Xeljanz/XR® (tofacitinib)

Product being requested: _____

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
MODERATE TO SEVERE ULCERATIVE COLITIS			
1. Has the member been diagnosed with moderate to severe Ulcerative Colitis?	☐	☐	**Please provide documentation**
2. Is the prescribing provider a gastroenterologist or in consultation with a gastroenterologist?	☐	☐	
3. Has the provider performed tuberculosis (TB) screening prior to therapy initiation?	☐	☐	**Please provide documentation**
4. If the request is for Tumor Necrosis Factor Inhibitors (TNFIs) or Xeljanz, has the provider performed hepatitis B screening prior to therapy initiation?	☐	☐	**Please provide documentation**
5. Has the member had an adequate trial and failure of at least one of the following, or contraindication to all: • High dose oral 5-aminosalicyclic acid drug • Topical 5-aminosalicylic acid drug	☐	☐	**Please provide documentation**
SEVERE ULCERATIVE COLITIS			

1. Has the member been diagnosed with severe Ulcerative Colitis? • Has the patient had more than 6 stools per day with blood OR has systemic symptoms (fever, tachycardia, anemia or erythrocyte sedimentation rate > 30mm/h)?	☐	☐	**Please provide documentation**
2. Is the prescribing provider a gastroenterologist or in consultation with a gastroenterologist?	☐	☐	**Please provide documentation**
3. Has the provider performed tuberculosis (TB) screening prior to therapy initiation?	☐	☐	**Please provide documentation**
4. Has the provider performed hepatitis B screening prior to therapy initiation?	☐	☐	**Please provide documentation**
FULMINANT COLITIS			
1. Has the member been diagnosed with fulminant colitis? • Has the member had more than 10 bowel movements per day with continuous bleeding OR has colonic dilation, transfusion requirement, or toxicity?	☐	☐	**Please provide documentation**
2. Is the prescribing provider a gastroenterologist or in consultation with a gastroenterologist?	☐	☐	**Please provide documentation**
3. Has the provider performed tuberculosis (TB) screening prior to therapy initiation?	☐	☐	**Please provide documentation**
4. 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 updated clinical documentation show a positive response to therapy, such as a decrease or stabilization in the Disease Activity Index (DAI) score?	☐	☐	**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's Signature:			

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

Policy: PHARM- 075
Origination Date: 03/30/2018
Reviewed/Revised Date: 01/27/2021
Next Review Date: 01/27/2022
Current Effective Date: 02/01/2021