

MEDICAL PRIOR AUTHORIZATION REQUEST FORM
CROHN'S DISEASE- MEDICAL INFUSED DRUGS

Entyvio®, Inflectra®, Remicade®, Renflexis®, Tysabri®

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 801-213-1547. 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: 833-981-0212, University of Utah Individual & Family Plans : 833-981-0214, University of Utah Commercial Groups: 833-981-0213, MHC: 844-262-1560, Advantage U Part B: 888-605-0858

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: Renflexis® (infliximab-abda)

Non-preferred: Entyvio® (vedolizumab)*, Inflectra® (infliximab-dyyb), Remicade® (infliximab), Tysabri® (natalizumab)

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?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does the member have moderate to severe Crohn's Disease and meet at least one of the following: <ul style="list-style-type: none"> • 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 adherence to Disease Modifying Anti-rheumatic Drug (DMARD) therapy for at least 3 months including at least one of the following: methotrexate, azathioprine, 6-mercaptopurine 	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
3. Has the provider performed tuberculosis (TB) screening prior to therapy initiation? <ul style="list-style-type: none"> • Not required if request is for Tysabri 	<input type="checkbox"/>	<input type="checkbox"/>	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?	<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 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?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
3. Has the provider performed continued tuberculosis monitoring during therapy?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. 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 Signature:			

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Policy: PHARM- M019
 Origination Date: 03/26/2020
 Reviewed/Revised Date: 01/27/2021
 Next Review Date: 01/27/2022
 Current Effective Date: 02/01/2021

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