

**MEDICAL PRIOR AUTHORIZATION REQUEST FORM
HIDRADENITIS SUPPURATIVA- MEDICAL INFUSED DRUGS**

Inflectra[®], Renflexis[®], Remicade[®]

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: Inflectra[®] (infliximab-dyyb), Remicade[®] (infliximab)

Dosing/Frequency: _____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Does the member have a diagnosis of moderate to severe (Hurley Stage II or III) Hidradenitis Suppurativa?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
2. Is the request made by, or in consultation with, a dermatologist?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Has smoking cessation, weight management, diet, and proper hygiene counseling been discussed with the member?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Has the member had a 90 day trial and failure of oral antibiotics?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
5. Has the provider performed tuberculosis (TB) screening prior to therapy initiation?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
6. Has the provider performed hepatitis B screening prior to therapy initiation?	<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 a Hidradenitis Suppurativa positive clinical response been seen and there is a continued need for therapy?			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

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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- M020
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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