HEALTH PLANS
UNIVERSITY OF UTAH

MEDICAL PRIOR AUTHORIZATION REQUEST FORM
JUVENILE IDIOPATHIC ARTHRITIS- MEDICAL INFUSED DRUGS
Inflectra®, Orencia®, Remicade®, Renflexis®

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), ☐ Orencia® (abatacept), ☐ Remicade® (infliximab)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Is the requesting made by, or in consultation with, a rheumatologist?	☐	☐	
2. Has the provider performed tuberculosis (TB) screening prior to therapy initiation?	☐	☐	**Please provide documentation**
3. Has the provider performed hepatitis screening prior to therapy initiation?	☐	☐	**Please provide documentation**
ACTIVE JOINT COUNT ≤ 4 WITHOUT SYSTEMIC FEATURES			
1. Does the member have an active joint count of **≤ 4** *without* systemic features?	☐	☐	**Please provide documentation**
2. Has the member had an adequate trial of a nonsteroidal anti-inflammatory drug (NSAID)?	☐	☐	**Please provide documentation**
3. Has the member had an adequate trial of methotrexate or leflunomide?	☐	☐	**Please provide documentation**
ACTIVE JOINT COUNT > 4 WITHOUT SYSTEMIC FEATURES			
1. Does the member have an active joint count of **> 4** *without* systemic features?	☐	☐	**Please provide documentation**
2. Has the member had an adequate trial of methotrexate or leflunomide?	☐	☐	**Please provide documentation**

SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (JIA)			
1. Does the member have mild to moderate systemic JIA?	☐	☐	**Please provide documentation**
2. Has the member had an adequate trial of NSAIDs?	☐	☐	
3. Does the member have moderate to severe systemic JIA?	☐	☐	**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 decrease or stabilization 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**
6. 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- M021
Origination Date: 03/26/2020
Reviewed/Revised Date: 01/27/2021
Next Review Date: 01/27/2022
Current Effective Date: 02/01/2021