

**MEDICAL PRIOR AUTHORIZATION REQUEST FORM**
**PSORIASIS- MEDICAL INFUSED DRUGS**

Inflectra®, Orenzia®, 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), Orenzia®  Remicade® (infliximab)

Dosing/Frequency: \_\_\_\_\_

**If the request is for reauthorization, proceed to reauthorization section**

Questions	Yes	No	Comments/Notes
1. Is the requesting provider a dermatologist or made in consultation with a dermatologist?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does the member have moderate to severe psoriasis based on the Psoriasis Area and Severity Index (PASI) and/or Body Surface Area Percentage (BSA%) OR high impact disease (plaques on palms/soles, scalp psoriasis, nail psoriasis)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Has the member had an adequate trial of phototherapy or photochemotherapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Has the member had an adequate trial of at least one of the following: methotrexate, cyclosporine A, acitretin?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Has the provider performed tuberculosis (TB) screening prior to therapy initiation?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Has the provider performed hepatitis B screening prior to therapy initiation?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

**REAUTHORIZATION**

1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
---	--------------------------	--------------------------	--

**Confidentiality Notice**

This document and any accompanying document contain confidential information and is intended for the use of the individual or entity named on this transmission sheet. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action in reliance on the contents of this information is strictly prohibited and the document should be returned to this office immediately. If you have received this facsimile in error, please notify us by telephone immediately and destroy document received.

2. Has the member's therapy been re-evaluated within the past 6 months?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Has the therapy shown to be tolerable and effective with an improvement in condition?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Does the member show a continued medical need for the therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
5. Has the provider performed continued tuberculosis monitoring during therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Has the provider performed continued Hepatitis B monitoring in HBV carriers?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
Additional information:			
Physician Signature:			

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

Policy: PHARM- M022  
 Origination Date: 03/26/2020  
 Reviewed/Revised Date: 01/27/2021  
 Next Review Date: 01/27/2022  
 Current Effective Date: 02/01/2021

**Confidentiality Notice**

This document and any accompanying document contain confidential information and is intended for the use of the individual or entity named on this transmission sheet. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action in reliance on the contents of this information is strictly prohibited and the document should be returned to this office immediately. If you have received this facsimile in error, please notify us by telephone immediately and destroy document received.