

**MEDICAL PRIOR AUTHORIZATION REQUEST FORM
RHEUMATOID ARTHRITIS- MEDICAL INFUSED DRUGS**

Actemra, Inflectra, Remicade, Renflexis, Rituxan, Truxima, Orencia

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 at least two 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), Truxima®(rituximab)

Non-preferred: Actemra® (tocilizumab), 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 request made by, or in consultation with, a rheumatologist?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the patient's condition moderate to severe based on the Disease Activity Score (DAS28) or is a tender and swollen joint count provided as well as C-reactive protein (CRP) or erythrocyte sedimentation?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
3. Has the patient had an adequate trial of at least one disease modifying antirheumatic drug (e.g. methotrexate, sulfasalazine, leflunomide, hydroxychloroquine)? NOTE: If oral methotrexate is not tolerated, intramuscular or subcutaneous methotrexate must be tried.	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Has the provider performed tuberculosis (TB) screening prior to therapy initiation?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
5. 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

REAUTHORIZATION

1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
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2. Has the patient experienced at least a 20% improvement in ACR or DAS28 score since therapy initiation? If moderate or high disease activity continues > 3 months due to lack of or loss of benefit, switching agents should be evaluated.	<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's Signature:			

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

Policy: PHARM- M024
 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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