HEALTH PLANS
UNIVERSITY OF UTAH

PRIOR AUTHORIZATION REQUEST FORM
ANKYLOSING SPONDYLITIS
Cimzia®, Enbrel®, Humira®, Simponi®, Taltz®

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 888-509-8142.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: University of Utah Health Employees: 855-856-5690, Individual & Family Plans : 855-869-4769, Commercial Groups: 855-859-4892, MHC 855-885-7695

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

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/Non-Preferred/Non-Formulary

1. Preferred Brands:
   A. Cimzia® (certolizumab), Humira® (adalimumab), Simponi® (golimumab)
2. Non-Preferred Brands with a single step; after trial and failure of at least 1 first line agent:
   A. Taltz® (ixekizumab)
3. Non-Preferred Brands with a triple step; after trial and failure of at least 2 preferred agents AND Taltz® (ixekizumab):
   A. Enbrel® (etanercept)
4. Non-Formulary: Cosentyx® (secukinumab)

Product being requested: _____

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Is the member 18 years of age or older with Ankylosing Spondylitis?	☐	☐	**Please provide documentation**
2. Is the requesting provider a rheumatologist or in consultation with one?	☐	☐	
3. Does documentation show an adequate trial and failure of at least one prescription strength nonsteroidal anti-inflammatory drug (NSAID) at the maximally tolerated dose, unless contraindicated?	☐	☐	**Please provide documentation**
4. Has the provider performed tuberculosis (TB) screening prior to therapy initiation?	☐	☐	**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?	☐	☐	**Please provide documentation**
6. If the request is for Xeljanz/XR, does documentation show an inadequate response or intolerance to at least one TNF (tumor necrosis factor) blocker such infliximab, Cimzia, Humira and/or Simponi AND does documentation show the member will not be receiving Xeljanz/XR in combination with a potent immunosuppressant (e.g., azathioprine or cyclosporine)?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does updated documentation show that the member has a continued medical need?	☐	☐	**Please provide documentation**
3. Does updated documentation show the member responded to therapy, such as a decrease in disease severity or disease stabilization in the Bath Ankylosing Spondylitis Disease Activity Index (BASAI) or the Ankylosing Spondylitis Disease Activity Score (ASDAS)?	☐	☐	**Please provide documentation**
4. Has the provider performed continued tuberculosis screening during therapy?	☐	☐	**Please provide documentation**
5. 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- 003
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