

**PRIOR AUTHORIZATION REQUEST FORM**
**PSORIATIC ARTHRITIS**

Cimzia®, Enbrel®, Humira®, Orencia®, Otezla®, Rinvoq, Simponi®, Skyrizi, Stelara®, Taltz®, Tremfya®,  
 Xeljanz/XR®

**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**

1. Preferred Agents:
  - A. Preferred:
    - i. Cimzia® (certolizumab), Humira® (adalimumab), Otezla® (apremilast), Rinvoq (upadacitinib), Simponi® (golimumab), Skyrizi (risankizumab-rzaa), Stelara® (ustekinumab), Tremfya® (guselkumab), Xeljanz/XR® (tofacitinib)
  - Non-preferred:
2. Non-Preferred with a single step after trial and failure of at least 1 first line agents agent with the exception of Otezla® (apremilast):
  - i. Taltz® (ixekizumab)
3. Non-Preferred with a double step; after trial and failure of at least 2 first line agents agent with the exception of Otezla® (apremilast):
  - i. Orencia® (abatacept)
4. Non-Preferred with a 4 step requirement; after trial and failure of at least 2 first line agents agent with the exception of Otezla® (apremilast) PLUS Orencia® (abatacept) and Taltz® (ixekizumab)
  - i. Enbrel® (etanercept)
5. Non-Formulary:
  - i. 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 patient 18 years of age or older with active psoriatic arthritis? | <input type="checkbox"/> | <input type="checkbox"/> | <b>Please provide documentation</b> |

|   |                          |                          |                                     |
|---|--------------------------|--------------------------|-------------------------------------|
| 2. Is the request from, or in consultation with, a rheumatologist or a dermatologist?   | <input type="checkbox"/> | <input type="checkbox"/> |                                     |
| 3. Has the patient had an adequate trial and failure of at least one of the following disease-modifying antirheumatic drugs (DMARDs), unless contraindicated to all: methotrexate, leflunomide, sulfasalazine, azathioprine, intra-articular glucocorticoid injections, hydroxychloroquine, D-penicillamine, or minocycline?  | <input type="checkbox"/> | <input type="checkbox"/> | <b>Please provide documentation</b> |
| 4. Does the member have moderate axial disease, severe disease, or enthesitis?<br><ul style="list-style-type: none"> <li>For patients with moderate axial disease, severe disease, or enthesitis, a trial and failure of a DMARD may not be necessary.</li> </ul>   | <input type="checkbox"/> | <input type="checkbox"/> | <b>Please provide documentation</b> |
| 5. If the request is for a Tumor Necrosis Factor Inhibitor or an Interleukin Receptor Antagonist, has the provider performed tuberculosis (TB) screening prior to therapy initiation?   | <input type="checkbox"/> | <input type="checkbox"/> | <b>Please provide documentation</b> |
| 6. 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"/> | <b>Please provide documentation</b> |
| 7. If the request is for Xeljanz/XR or Rinvoq, does documentation show an inadequate response or intolerance to at least one TNF (tumor necrosis factor) blocker such as infliximab, Cimzia, Humira and/or Simponi AND does documentation show the member will not be receiving Xeljanz/XR or Rinvoq in combination with a potent immunosuppressant (e.g., azathioprine or cyclosporine)? | <input type="checkbox"/> | <input type="checkbox"/> | <b>Please provide documentation</b> |
| <b>REAUTHORIZATION</b>  |                          |                          |                                     |
| 1. Is the request for reauthorization of therapy?   | <input type="checkbox"/> | <input type="checkbox"/> |                                     |
| 2. Has the member's therapy been re-evaluated within the past 12 months?  | <input type="checkbox"/> | <input type="checkbox"/> |                                     |
| 3. Has the therapy shown to be tolerable and effective with a significant decrease in disease severity?   | <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> |
| 1. 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>  |                          |                          |                                     |

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Additional information:

Physician's Signature:

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

Policy PHARM- 062

Origination Date: 03/27/2018

Reviewed/Revised Date: 03/16/2022

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