UTAH MEDICAID PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Non-preferred Immunomodulators

Member and Medication Information * indicates required field	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/ Strength:	
☐ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.	
*Directions for use:	
Provider Information * indicates required field	
*Requesting Provider Name:	*Requesting Prescriber NPI:
Address:	
*Contact Person:	*Office Phone:
*Office Fax:	*Office Email:
Medically Billed Information * indicates required field for all medically billed products	
*Diagnosis Code:	*HCPCS Code:
*Dosing Frequency:	*HCPCS Units per Dose:
Servicing Provider Name:	NPI:
Servicing Provider Address:	
Facility/Clinic Name:	NPI:
Facility/Clinic Address:	
Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at **855-828-4992**, to prevent processing delays.	

Criteria for Approval: (*All* of the following criteria must be met)

1. Does the patient have a documented diagnosis of a condition listed on the medication's FDA-approved label? ❑ **Yes** ❑ **No**
   Condition: _____
   ☐ Other confirmation testing, if applicable Chart Note Page #: _____
2. Is the medication being prescribed by or in consultation with a provider specializing in the disease treatment? ❑ **Yes** ❑ **No**
3. Does the use of medication follow FDA-approved label use instructions *(including age, dose, monitoring for boxed warnings and contraindications*)? ❑ **Yes** ❑ **No**
4. Has the provider submitted documentation of appropriate first-line treatments or interventions, if current treatment standards recommend other treatment(s) prior to use of the requested drug? ❑ **Yes** ❑ **No**
   Medication: _____ Date of therapy: _____
   Details of Failure: _____
5. Has the patient tried and failed at least **TWO** preferred products in the immunomodulator therapeutic class for a minimum of three months or has the prescriber demonstrated medical necessity for a non-preferred product, if applicable? ❑ **Yes** ❑ **No**

Medication(1): _____ Date of therapy: _____
Details of Failure: _____
Medication(2): _____ Date of therapy: _____
Details of Failure: _____

6. Does the provider attest that the patient is not on concurrent treatment or that the medication will not be used in combination with other TNF-inhibitors, biologic response modifiers or other biologic DMARDs, Janus kinase Inhibitors, or Phosphodiesterase 4 inhibitors (i.e., apremilast, tofacitinib, baricitinib) as verified by prescriber attestation, patient's medication fill history, or submitted documentation? ❑ **Yes** ❑ **No**

Off Label or Compendia Use of FDA-Approved Drugs Additional Criterion:

1. Does the clinical documentation show an adequate trial and failure of at least **ONE** FDA-labeled and Medicaid preferred medication, if applicable? ❑ **Yes** ❑ **No**
2. Does the provider attest that the requested drug is being used for a medically accepted indication that is supported by information from the appropriate *compendia** of current literature. Including at least (1) major multi-site study or three (3) smaller studies published in JAMA, NEJM, Lancet, or other peer review specialty medical journals in the most recent years? ❑ **Yes** ❑ **No**

   * Compendia use must be recommended by generally accepted compendia such as American Hospital Formulary Service Drug Information (AHFS), United States Pharmacopeia-Drug Information (USP-DI), the Micromedex Information System, Pediatric and Neonatal Lexi-Drugs, or clinical guidelines.

Reauthorization Criteria:

1. Has the provider submitted updated chart notes demonstrating a positive clinical response? ❑ **Yes** ❑ **No**

Initial Authorization: Up to six (6) months
Reauthorization: Up to one (1) year

Note:

- The patient must have regular appointments to receive or follow up on the medication in the provider's office. The patient must remain in the office for an adequate amount of time to allow for observation and treatment of anaphylaxis, if necessary. If/when any change of dose is requested, the prescriber must indicate, in writing, the reasoning for the dose increase.

PROVIDER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____

Prescriber's Signature Date