HEALTH | CHOICE
UTAH

April 1, 2022

Changes to the Health Choice Utah Formulary

Health Choice Utah may add or remove drugs from the formulary during the year. If a drug that you are currently using is scheduled to be removed from the formulary, you will be notified at least 60 days before the change becomes effective. In cases where the U.S. Food and Drug Administration (FDA) deems a drug unsafe, or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from the formulary and notify you afterward.

PA=Prior Authorization is required, QL= Quantity Limit, ST= Step Therapy

Upcoming Changes

Effective Date	Label Name	Description of Change	Preferred Alternative
4/1/2022	BENZOYL PEROXIDE LIQ 7%	Now Non-Preferred	OTC Benzoyl Peroxide
4/1/2022	BENZOYL PEROXIDE FOAM 9.8%	Now Non-Preferred	OTC Benzoyl Peroxide
4/1/2022	BENZOYL PEROXIDE GEL 4%	Now Non-Preferred	OTC Benzoyl Peroxide
4/1/2022	BENZOYL PEROXIDE GEL 8%	Now Non-Preferred	OTC Benzoyl Peroxide
4/1/2022	BENZOYL PEROXIDE CLOTH 6%	Now Non-Preferred	OTC Benzoyl Peroxide
4/1/2022	Doxycycline monohydrate 150 mg capsule	Now Non-Preferred	Doxycycline monohydrate 150 mg tablet
4/1/2022	Doxycycline monohydrate 75 mg capsule	Now Non-Preferred	Doxycycline monohydrate 75 mg tablet
4/1/2022	Doxycycline hyclate 75 mg tablet	Now Non-Preferred	Doxycycline monohydrate 75 mg tablet
4/1/2022	Doxycycline hyclate 200 mg DR tablet	Now Non-Preferred	Doxycycline hyclate 100 mg DR tablet
4/1/2022	TRETIN-X 0.075 % CREAM	Now Non-Preferred	TRETINOIN CREAM 0.025%, TRETINOIN CREAM 0.05%, TRETINOIN CREAM 0.1%
4/1/2022	ADAPALENE LOTION 0.1%	Now Non-Preferred	ADAPALENE GEL 0.1%, ADAPALENE GEL 0.3%

Effective Date	Label Name	Description of Change	Preferred Alternative
4/1/2022	CLINDAMYCIN PHOSPHATE-TRETINOIN GEL 1.2-0.025%	Now Non-Preferred	TRETINOIN GEL 0.025%, CLINDAMYCIN PHOSPHATE GEL 1%
4/1/2022	CLINDAMYCIN PHOSPHATE SWAB 1% & CLEANSER KIT	Now Non-Preferred	CLINDAMYCIN PHOSPHATE GEL 1%
4/1/2022	CLINDAMYCIN-BENZOYL PEROX GEL 1.2-5% & MOISTURIZER CR KIT	Now Non-Preferred	CLINDAMYCIN PHOSPHATE GEL 1%, OTC Benzoyl Peroxide
4/1/2022	BENZOYL PEROXIDE PAD 8% & VITAMIN E TOPICAL 5% KIT	Now Non-Preferred	OTC Benzoyl Peroxide
4/1/2022	BENZOYL PEROX PAD 8% & SALICYLIC AC PAD 2% & VIT E 5% KIT	Now Non-Preferred	OTC Benzoyl Peroxide
4/1/2022	BENZOYL PEROXIDE-HYDROCORTISONE LOTION 5-0.5%	Now Non-Preferred	OTC Benzoyl Peroxide
4/1/2022	SULFACETAMIDE SODIUM W/ SULFUR SUSP 10-5%	Now Non-Preferred	SULFACETAMIDE SODIUM W/ SULFUR CLNSER 10-5%
4/1/2022	SULFACETAMIDE SODIUM W/ SULFUR LOTION 10-5%	Now Non-Preferred	SULFACETAMIDE SODIUM W/ SULFUR CLNSER 10-5%
4/1/2022	SULFACETAMIDE SODIUM-SULFUR IN UREA EMULSION 10-5%	Now Non-Preferred	SULFACETAMIDE SODIUM W/ SULFUR CLNSER 10-5%
4/1/2022	SULFACETAMIDE SODIUM W/ SULFUR CLEANSING PAD 10-4%	Now Non-Preferred	SULFACETAMIDE SODIUM W/ SULFUR CLNSER 10-5%
4/1/2022	SULFACETAMIDE SODIUM W/ SULFUR CREAM 10-2%	Now Non-Preferred	SULFACETAMIDE SODIUM W/ SULFUR CLNSER 10-5%
4/1/2022	SULFACETAMIDE SODIUM W/ SULFUR CLEANSER 9.8-4.8%	Now Non-Preferred	SULFACETAMIDE SODIUM W/ SULFUR CLNSER 10-5%
4/1/2022	SULFACETAMIDE SODIUM W/ SULFUR CREAM 9.8-4.8%	Now Non-Preferred	SULFACETAMIDE SODIUM W/ SULFUR CLNSER 10-5%
4/1/2022	SULFACETAMIDE SODIUM W/ SULFUR LOTION 9.8-4.8%	Now Non-Preferred	SULFACETAMIDE SODIUM W/ SULFUR CLNSER 10-5%
4/1/2022	SULFACETAMIDE SOD-SULFUR WASH 9-4.5% & SKIN CLEANSER KIT	Now Non-Preferred	SULFACETAMIDE SODIUM W/ SULFUR CLNSER 10-5%
6/1/2022	Rinvoq	Now Non-Preferred	Depends on Disease State- see table below
6/1/2022	Enbrel	Now Non-Preferred	Depends on Disease State- see table below
6/1/2022	Kineret	Now Non-Preferred	Depends on Disease State- see table below
6/1/2022	Ilumya	Now Non-Preferred	Depends on Disease State- see table below
6/1/2022	Simponi	Now Non-Preferred	Depends on Disease State- see table below
6/1/2022	Stelara	Now Non-Preferred	Depends on Disease State- see table below
6/1/2022	Skyrizi	Now Non-Preferred	Depends on Disease State- see table below
6/1/2022	Tremfya	Now Non-Preferred	Depends on Disease State- see table below

The preferred/non-preferred medications for autoimmune diseases for Health Choice Utah members are changing on June 1, 2022. These changes are listed below and apply to new starts.

Disease State	First line preferred	Second line preferred; after trial and failure of one first-line agent	Non preferred; requires trial and failure of one first-line and two second-line agents
Rheumatoid Arthritis	Preferred Infliximab products Rituximab	Actemra, Cimzia, Humira, Kevzara, Olumiant, Orencia, Xeljanz/XR	Enbrel, Kineret, Rinvoq, Simponi
Ankylosing Spondylitis	Preferred Infliximab products	Cimzia, Humira, Taltz, Xeljanz/XR	Enbrel, Cosentyx, Simponi
Psoriasis	Preferred infliximab products	Cimzia, Humira, Otezla, Taltz	Cosentyx, Enbrel, Ilumya, Siliq, Stelara, Skyrizi, Tremfya
Psoriatic Arthritis	Preferred Infliximab products	Cimzia, Humira, Orencia, Otezla, Taltz, Xeljanz/XR	Cosentyx, Enbrel, Rinvoq, Simponi, Skyrizi, Stelara, Tremfya
Crohn's Disease	Preferred Infliximab products	Cimzia, Entyvio, Humira	Stelara
Ulcerative Colitis	Preferred Infliximab products	Entyvio, Humira, Xeljanz/XR	Simponi, Stelara
Juvenile Idiopathic Arthritis	Preferred Infliximab products, Actemra, Orencia	Humira, Xeljanz/XR	Enbrel
Hidradenitis Suppurativa	Preferred Infliximab, products	Humira	

HEALTH | CHOICE
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PRIOR AUTHORIZATION REQUEST FORM
ANKYLOSING SPONDYLITIS
Cimzia®, Cosentyx®, Enbrel®, Humira®, Inflectra®, Remicade®, Renflexis®, Simponi®, Taltz®, Xeljanz/XR®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department.

- For **Medical Pharmacy** please fax requests to 801-646-7300
- For **Retail Pharmacy** requests please fax requests to: 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: 855-864-1404

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:Cosentyx® (secukinumab), Enbrel® (etanercept)

1. 1st Line Preferred agents:
   A. Infliximab products: Inflectra® (infliximab-dyyb), Remicade® (infliximab), Renflexis® (infliximab-abda)
2. 2nd line preferred agents with single step; after trial and failure of 1 first line agent:
   A. Cimzia® (certolizumab), Humira® (adalimumab), Taltz® (ixekizumab), Xeljanz/XR® (tofacitinib)
3. Non-Preferred agents with a triple step; after trial and failure of 1 first line agent and 2 second line agents:
   A. Cosentyx® (secukinumab), Enbrel® (etanercept), Simponi® (golimumab)

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 Xejanz/XR, does documentation show inadequate response or intolerance to at least one TNF (tumor necrosis factor) blocker such infliximab, Cimzia, Humira and/or Simponi?	☐	☐	**Please provide documentation**
7. If the request is for Xejanz/XR, 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:			

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

Policy PHARM-HCU-003
Origination Date: 01/01/2022
Reviewed/Revised Date: 03/24/2022
Next Review Date: 03/24/2023
Current Effective Date: 06/01/2022

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
CROHN'S DISEASE MEDICATIONS
Cimzia®, Entyvio®, Humira®, Inflectra®, Remicade®, Renflexis®, Stelara®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department.

- For **Medical Pharmacy** please fax requests to 801-646-7300
- For **Retail Pharmacy** requests please fax requests to: 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: 855-864-1404

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. 1st Line Preferred Agents:
   A. Infliximab products: Inflectra® (infliximab-dyyb), Remicade (infliximab), Renflexis® (infliximab-abda)
2. 2nd line preferred agents with single step; after trial and failure of 1 first line agent:
   A. Cimzia® (certolizumab), Entyvio® (vedolizumab), Humira® (adalimumab)
3. Non-Preferred agents with a triple step; after trial and failure of 1 first line agent and 2 second line agents:
   A. Stelara® (ustekinumab)

Product being requested: _____

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Is the request being made by or in consultation with a gastroenterologist?	☐	☐	
2. Does documentation include results from studies such as colonoscopy, MRI, CT scan?	☐	☐	**Please provide documentation**
3. Does the member have severe Crohn's Disease evidenced by at least one of the following: • A Crohn's Disease Activity Score (CDAI) >220 AND as shown on imaging • Active fistulizing disease	☐	☐	**Please provide documentation**

4. Does the member have moderate to severe Crohn's Disease evidenced by the following: • Persistent fistulizing disease or active ulcerative disease as shown on imaging and via CDAI > 150 despite an adequate trial with a Disease Modifying Anti-rheumatic Drug (DMARD) such as methotrexate, azathioprine or 6-mercaptopurine, unless contraindicated to all.	☐	☐	**Please provide documentation**
5. Has the provider performed tuberculosis (TB) screening prior to therapy initiation?	☐	☐	**Please provide documentation**
6. If the request is for a Tumor Necrosis Factor Inhibitor, has the provider performed hepatitis B screening prior to therapy initiation?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does documentation show a stabilization or decrease in the CDAI score of at least 70 points compared to baseline, endoscopic improvement in mucosa and/or no new fistulizing disease information?	☐	☐	**Please provide documentation**
3. Has the provider performed continued tuberculosis monitoring during therapy?	☐	☐	**Please provide documentation**
4. 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 Signature:			

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

Policy: PHARM-HCU-019
Origination Date: 01/01/2022
Reviewed/Revised Date: 03/24/2022
Next Review Date: 03/24/2023
Current Effective Date: 06/01/2022

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
HIDRADENITIS SUPPURATIVA
Humira®, Inflectra®, Renflexis®, Remicade®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department.

- For **Medical Pharmacy** please fax requests to 801-646-7300
- For **Retail Pharmacy** requests please fax requests to: 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: 855-864-1404

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. 1st Line Preferred Agents:
   A. Infliximab products: Inflectra® (infliximab-dyyb), Remicade (infliximab), Renflexis® (infliximab-abda)
2. 2nd line preferred agents with single step; after trial and failure of at least 1 first line agent:
   A. Humira® (adalimumab)

Product being requested: _____

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Does the member have a diagnosis of moderate to severe (Hurley Stage II or III) Hidradenitis Suppurativa?	☐	☐	**Please provide documentation**
2. Is the requesting provider a dermatologist or in consultation with a dermatologist?	☐	☐	
3. Has smoking cessation, weight management, diet, and proper hygiene counseling been discussed with the member?	☐	☐	**Please provide documentation**
4. Has the member had an inadequate response to ≥ 90 day trial of oral antibiotics, unless contraindicated?	☐	☐	**Please provide documentation**
5. If the request is for Humira, does documentation include baseline inflammatory lesion (abscesses + inflammatory nodules) and draining fistulas count?	☐	☐	**Please provide documentation**
6. Has the provider performed tuberculosis (TB) screening prior to therapy initiation?	☐	☐	**Please provide documentation**

7. Has the provider performed hepatitis B screening prior to therapy initiation?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has a Hidradenitis Suppurativa Clinical Response been seen by week 16 of therapy, defined as a ≥50% decrease in inflammatory lesion count (abscesses + inflammatory nodules) and no increase in abscesses or draining fistulas compared to baseline?	☐	☐	**Please provide documentation**
3. Has the provider performed continued tuberculosis monitoring during therapy?	☐	☐	**Please provide documentation**
4. 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:

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

Policy PHARM-HCU-032
Origination Date: 01/01/2022
Reviewed/Revised Date: 03/24/2022
Next Review Date: 03/24/2023
Current Effective Date: 06/01/2022

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
JUVENILE IDIOPATHIC ARTHRITIS MEDICATIONS

Actemra®, Enbrel®, Humira®, Inflectra®, Orencia®, Remicade®, Renflexis®, Xeljanz/XR®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department.

- For **Medical Pharmacy** please fax requests to 801-646-7300
- For **Retail Pharmacy** requests please fax requests to: 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: 855-864-1404

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. 1st Line Preferred Agents:
   A. Infliximab products: [Inflectra® (infliximab-dyyb), Remicade® (infliximab), Renflexis® (infliximab-abda)], Actemra® (tocilizumab), Orencia® (abatacept)
2. 2nd line preferred agents with single step:
   A. Humira® (adalimumab), Xeljanz®/Xeljanz XR® (tofacitinib)
3. Non-Preferred Brands with a triple step; after trial and failure of 1 first line agent and 2 second line agents:
   A. Enbrel® (etanercept)

Product being requested: _____

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Does the member have a documented diagnosis of Juvenile Idiopathic Arthritis?	☐	☐	**Please provide documentation**
2. Is the requesting prescriber a rheumatologist or working in consultation with a rheumatologist?	☐	☐	
3. Has the provider performed tuberculosis (TB) screening prior to therapy initiation?	☐	☐	**Please provide documentation**
4. If the request is for a Tumor Necrosis Factor Inhibitor or Orencia®, has the provider performed hepatitis B screening prior to therapy initiation?	☐	☐	**Please provide documentation**

5. If the request is for Xejanz/XR, does documentation show an inadequate response or intolerance to at least one tumor necrosis factor (TNF) 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**
ACTIVE JOINT COUNT ≤ 4 WITHOUT SYSTEMIC FEATURES			
1. Does the member have an active joint count of **≤ 4** *without* systemic features?	☐	☐	**Please provide documentation**
2. Has the member had an adequate trial of, or intolerance/contraindication to, a nonsteroidal anti-inflammatory drug (NSAID)?	☐	☐	**Please provide documentation**
3. Has the member had an adequate trial of, or intolerance/contraindication to, methotrexate or leflunomide?	☐	☐	**Please provide documentation**
4. Is the request for the preferred product, Humira®?	☐	☐	
ACTIVE JOINT COUNT > 4 WITHOUT SYSTEMIC FEATURES			
1. Does the member have an active joint count of **> 4** *without* systemic features?	☐	☐	**Please provide documentation**
2. Has the member had a 3-month trial of, or intolerance/contraindication to, methotrexate or leflunomide?	☐	☐	**Please provide documentation**
MILD TO MODERATE ACUTE DISEASE WITH SYSTEMIC FEATURES			
1. Does the member have mild to moderate acute disease with systemic features of nondisabling symptoms without evidence of macrophage activation syndrome?	☐	☐	**Please provide documentation**
2. Has the member had an adequate trial of, or intolerance/contraindication to, a nonsteroidal anti-inflammatory drug (NSAID)?	☐	☐	**Please provide documentation**
MODERATE TO SEVERE ACUTE DISEASE WITH SYSTEMIC FEATURES			
1. Has the member shown systemic symptoms such as high fevers with poor response to NSAIDs, other serious systemic manifestations including serositis and possible early macrophage activation syndrome, and/or moderate-to-severe polyarthritis?	☐	☐	**Please provide documentation**
SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (JIA)			
1. Does the member have mild to moderate systemic JIA?	☐	☐	**Please provide documentation**
2. Has the member had an adequate trial of NSAIDs?	☐	☐	
3. Does the member have moderate to severe systemic JIA?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member's therapy been re-evaluated within the past 12 months?	☐	☐	
3. Has the therapy shown to be tolerable and effective with a decrease or stabilization in disease severity?	☐	☐	**Please provide documentation**
4. Does the member show a continued medical need for the therapy?	☐	☐	**Please provide documentation**
5. Has the provider performed continued tuberculosis monitoring during therapy?	☐	☐	**Please provide documentation**
6. 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:

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

Policy PHARM-HCU-041
Origination Date: 01/01/2022
Reviewed/Revised Date: 03/24/2022
Next Review Date: 03/24/2023
Current Effective Date: 06/01/2022

HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
PSORIASIS

Cimzia®, Cosentyx®, Enbrel®, Humira®, Ilumya™, Inflectra®, Otezla®, Remicade®, Renflexis®, Siliq™, Skyrizi™, Stelara®, Taltz®, Tremfya®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department.

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- For **Retail Pharmacy** requests please fax requests to: 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: 855-864-1404

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. 1st Line Preferred Agents:
   A. Infliximab products: Inflectra® (infliximab-dyyb), Remicade® (infliximab), Renflexis® (infliximab-abda)
2. 2nd line preferred agents with single step; after trial and failure of 1 first line agent:
   A. Cimzia® (certolizumab), Humira® (adalimumab), Otezla® (apremilast), Taltz® (ixekizumab)
3. Non-Preferred Agents with a triple step; after trial and failure of 1 first line agent and 2 second line agents:
   A. Cosentyx® (secukinumab), Enbrel® (etanercept), Ilumya® (tildrakizumab), Siliq™ (brodalumab), Stelara® (ustekinumab), Skyrizi® (risankizumab-rzaa), Tremfya® (guselkumab)

Product being requested: _____

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Is the request made by a dermatologist or made in consultation with a dermatologist?	☐	☐	
2. Does the member have moderate to severe psoriasis disease 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)? **Note:** Otezla does not require documentation of severity	☐	☐	**Please provide documentation**
3. Has the member had an adequate trial and failure of, or contraindication to, phototherapy or photochemotherapy?	☐	☐	**Please provide documentation**

4. Has the member had an adequate trial and failure of at least one, or contraindication to all three, of the following: methotrexate, cyclosporine A, and acitretin?	☐	☐	**Please provide documentation**
5. Has the provider performed tuberculosis (TB) screening prior to therapy initiation? (Note: NOT required if the request is for Otezla)	☐	☐	**Please provide documentation**
6. If the request is for a Tumor Necrosis Factor Inhibitor, has the provider performed hepatitis B screening prior to therapy initiation?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member's therapy been re-evaluated within the past 6 months?	☐	☐	
3. Has the therapy shown to be tolerable and effective with an improvement in condition?	☐	☐	**Please provide documentation**
4. Does the member show a continued medical need for the therapy?	☐	☐	**Please provide documentation**
5. Has the provider performed continued tuberculosis monitoring during therapy?	☐	☐	**Please provide documentation**
6. 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 Signature:			

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

Policy PHARM-HCU-061
Origination Date: 01/01/2022
Reviewed/Revised Date: 03/24/2022
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HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
PSORIATIC ARTHRITIS

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

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department.

- For **Medical Pharmacy** please fax requests to 801-646-7300
- For **Retail Pharmacy** requests please fax requests to: 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: 855-864-1404

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. 1st Line Preferred Agents:
   A. Infliximab products: Inflectra® (infliximab-dyyb), Remicade (infliximab), Renflexis® (infliximab-abda)
2. 2nd line preferred agents with single step; after trial and failure of 1 first line agent:
   A. Cimzia® (certolizumab), Humira® (adalimumab), Orencia® (abatacept), Otezla® (apremilast), Taltz® (ixekizumab), Xeljanz/XR ® (tofacitinib)
3. Non-Preferred Agents with a triple step; after trial and failure of 1 first line agent and 2 second line agents:
   A. Cosentyx® (secukinumab), Enbrel® (etanercept), Rinvoq® (upadacitinib), Skyrizi® (risankizumab-rzaa) Simponi® (golimumab), Stelara® (ustekinumab), Tremfya® (guselkumab)

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?	☐	☐	**Please provide documentation**
2. Is the request from, or in consultation with, a rheumatologist or a dermatologist?	☐	☐	
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	☐	☐	**Please provide documentation**

glucocorticoid injections, hydroxychloroquine, D-penicillamine, or minocycline?			
4. Does the member have moderate axial disease, severe disease, or enthesitis? • For patients with moderate axial disease, severe disease, or enthesitis, a trial and failure of a DMARD may not be necessary.	☐	☐	**Please provide documentation**
5. If the request is for Xeljanz/XR®, does documentation show 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**
6. 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?	☐	☐	**Please provide documentation**
7. If the request is for a Tumor Necrosis Factor Inhibitor, has the provider performed hepatitis B screening prior to therapy initiation?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member's therapy been re-evaluated within the past 12 months?	☐	☐	
3. Has the therapy shown to be tolerable and effective with a significant decrease in disease severity?	☐	☐	**Please provide documentation**
4. Does the member show a continued medical need for the therapy?	☐	☐	**Please provide documentation**
5. Has the provider performed continued tuberculosis monitoring during therapy?	☐	☐	**Please provide documentation**
6. 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:			

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

Policy PHARM-HCU-062
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HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
RHEUMATOID ARTHRITIS

Actemra®, Cimzia®, Enbrel®, Humira®, Inflectra®, Kevzara®, Kineret®, Olumiant®, Orencia®, Remicade®, Renflexis®, Rinvoq®, Rituxan®, Simponi®, Trazimera™, Truxima®, Xeljanz®/XR

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department.

- For **Medical Pharmacy** please fax requests to 801-646-7300
- For **Retail Pharmacy** requests please fax requests to: 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: 855-864-1404

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 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/Non-Preferred

1. 1st Line Preferred Agents:
   A. Infliximab products: Inflectra® (infliximab-dyyb), Remicade® (infliximab), Renflexis® (infliximab-abda)
   B. Rituximab products: Rituxan® (rituximab), Trazimera™ (rituximab-abbs), Truxima® (rituximab-qyyp)
2. 2nd line preferred agents with single step; after trial and failure of 1 first line agent:
   A. Actemra® (tocilizumab), Cimzia® (certolizumab), Humira® (adalimumab), Kevzara® (sarilumab), Olumiant® (baricitinb), Orencia® (abatacept), Xeljanz/XR® (tofacitinib)
3. Non-Preferred Agents with a triple step; after trial and failure of 1 first line agent and 2 second line agents:
   A. Enbrel® (etanercept), Kineret® (anakinra), Rinvoq® (upadacitinib), Simponi® (golimumab)

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?	☐	☐	
2. Is the requesting provider a rheumatologist or in consultation with a rheumatologist?	☐	☐	
3. 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 rate (ESR)?	☐	☐	**Please provide documentation**
4. Has the patient had an adequate trial and failure of at least one disease modifying antirheumatic drug (DMARD) (e.g.	☐	☐	**Please provide documentation**

hydroxychloroquine, leflunomide, methotrexate, sulfasalazine) or contraindication to all?			
5. If the request is for Rinvoq, Olumiant, or Xeljanz/XR, does documentation show 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 Rinvoq, Olumiant, or Xeljanz/XR in combination with a potent immunosuppressant (e.g., azathioprine or cyclosporine)?	☐	☐	**Please provide documentation**
6. 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?	☐	☐	**Please provide documentation**
7. If the request is for a Tumor Necrosis Factor Inhibitor, has the provider performed hepatitis B screening prior to therapy initiation?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the patient experienced at least a 20% improvement in ACR or DAS28 score since therapy initiation?	☐	☐	**Please provide documentation**
3. Has the provider performed continued tuberculosis monitoring during therapy?	☐	☐	**Please provide documentation**
4. 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:			

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

Policy PHARM-HCU-065
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HEALTH | CHOICE
UTAH

PRIOR AUTHORIZATION REQUEST FORM
ULCERATIVE COLITIS
Entyvio®, Humira®, Inflectra®, Remicade®, Renflexis®, Simponi®, Stelara®, Xeljanz®

For authorization, please answer each question and fax this form PLUS chart notes back to the Health Choice Utah Prior Authorization Department.

- For **Medical Pharmacy** please fax requests to 801-646-7300
- For **Retail Pharmacy** requests please fax requests to: 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: 855-864-1404

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. 1st Line Preferred Agents:
   A. Inflectra® (infliximab-dyyb), Remicade® (infliximab), Renflexis® (infliximab-abda)
2. 2nd line preferred agents with single step; after trial and failure of 1 first line agent:
   A. Enytvio® (vedolizumab), Humira® (adalimumab), Xeljanz®/XR (tofacitinib)
3. Non-Preferred Agents with a triple step; after trial and failure of 1 first line agent and 2 second line agents:
   A. Simponi® (golimumab), Stelara® (ustekinumab)

Product being requested: _____

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
MODERATE TO SEVERE ULCERATIVE COLITIS			
1. Has the member been diagnosed with moderate to severe Ulcerative Colitis?	☐	☐	**Please provide documentation**
2. Is the prescribing provider a gastroenterologist or in consultation with a gastroenterologist?	☐	☐	
3. Has the provider performed tuberculosis (TB) screening prior to therapy initiation?	☐	☐	**Please provide documentation**
4. If the request is for Tumor Necrosis Factor Inhibitors (TNFIs) or Xeljanz, has the provider performed hepatitis B screening prior to therapy initiation?	☐	☐	**Please provide documentation**

5. Has the member had an adequate trial and failure of at least one of the following, or contraindication to all: • High dose oral 5-aminosalicyclic acid drug • Topical 5-aminosalicylic acid drug	☐	☐	**Please provide documentation**
6. If the request is for Xeljanz/XR®, does documentation show inadequate response or intolerance to at least one tumor necrosis factor (TNF) 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**
SEVERE ULCERATIVE COLITIS			
1. Has the member been diagnosed with severe Ulcerative Colitis? • Has the patient had more than six stools per day with blood OR has systemic symptoms (fever, tachycardia, anemia or erythrocyte sedimentation rate > 30mm/h)?	☐	☐	**Please provide documentation**
2. Is the prescribing provider a gastroenterologist or in consultation with a gastroenterologist?	☐	☐	**Please provide documentation**
3. Has the provider performed tuberculosis (TB) screening prior to therapy initiation?	☐	☐	**Please provide documentation**
4. Has the provider performed hepatitis B screening prior to therapy initiation?	☐	☐	**Please provide documentation**
5. If the request is for Xeljanz/XR®, does documentation show inadequate response or intolerance to at least one tumor necrosis factor (TNF) 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**
FULMINANT COLITIS			
1. Has the member been diagnosed with fulminant colitis? • Has the member had more than 10 bowel movements per day with continuous bleeding OR has colonic dilation, transfusion requirement, or toxicity?	☐	☐	**Please provide documentation**
2. Is the prescribing provider a gastroenterologist or in consultation with a gastroenterologist?	☐	☐	**Please provide documentation**
3. Has the provider performed tuberculosis (TB) screening prior to therapy initiation?	☐	☐	**Please provide documentation**
4. Has the provider performed hepatitis B screening prior to therapy initiation?	☐	☐	**Please provide documentation**
5. If the request is for Xeljanz/XR®, does documentation show inadequate response or intolerance to at least one tumor necrosis factor (TNF) 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 clinical documentation show a positive response to therapy, such as a decrease or stabilization in the Disease Activity Index (DAI) score?	☐	☐	**Please provide documentation**

3. Has the provider performed continued tuberculosis monitoring during therapy?	☐	☐	**Please provide documentation**
4. 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:

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

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