



PRIOR AUTHORIZATION REQUEST

VELSIPITY

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number:	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength:	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for ALL PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Is the request for an INITIAL or a CONTINUATION of therapy?	
	<input type="checkbox"/> Initial (If checked, go to 8)	
	<input type="checkbox"/> Continuation (If checked, go to 2)	
2	Will the requested medication be used in combination with a biologic or with a targeted synthetic disease-modifying antirheumatic drug (DMARD) used for an inflammatory condition?	Yes No

**If you have any
questions, call:
1-888-258-8250**

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[NOTE: Biologic DMARDs include Actemra (IV or SC), Kevzara, Cosentyx, Kineret, Orencia (IV or SC), a rituximab product (for example, Rituxan, Truxima), Cimzia, Enbrel, Humira, an infliximab product (for example, Remicade, Inflectra, Renflexis), Simponi (Aria or SC), Ilumya, Siliq, Stelara (IV or SC), or Taltz and targeted synthetic DMARDs include: Xeljanz/XR, Olumiant, Rinvoq, or Otezla.]
[If yes, no further questions.]

- | | | | |
|----|---|-----|----|
| 3 | Is the patient currently receiving the requested medication?
[If no, skip to question 8.] | Yes | No |
| 4 | Has the patient been receiving medication samples of the requested medication?
[If yes, skip to question 8.] | Yes | No |
| 5 | Does the patient have a previously approved prior authorization (PA) on file with the current plan?
[Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.]
[If no, skip to question 8.] | Yes | No |
| 6 | Has the patient been established on therapy for AT LEAST 3 months?
[If no, skip to question 8.] | Yes | No |
| 7 | Has documentation been submitted to confirm that the patient has had a clinically significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation.
[Note: Examples of a beneficial response include an improvement in inflammatory response include fecal markers (e.g., fecal calprotectin), serum markers (e.g., C-reactive protein), endoscopic assessment, and/or reduced dose of corticosteroids or improvement in at least one symptom, such as decreased pain, fatigue, stool frequency, and/or decreased rectal bleeding.]
[No further questions.] | Yes | No |
| 8 | What is the diagnosis or indication?
<input type="checkbox"/> Ulcerative Colitis (If checked, go to 9)

<input type="checkbox"/> Other (If checked, no further questions) | | |
| 9 | Is the patient greater than or equal to 18 years of age or older?
[If no, no further questions.] | Yes | No |
| 10 | Will the requested medication be used in combination with a biologic or with a targeted synthetic disease-modifying antirheumatic drug (DMARD) used for an inflammatory condition?
[NOTE: Biologic DMARDs include Actemra (IV or SC), Kevzara, Cosentyx, Kineret, Orencia (IV or SC), a rituximab product (for example, Rituxan, Truxima), Cimzia, Enbrel, Humira, an infliximab product (for example, Remicade, Inflectra, Renflexis), Simponi (Aria or SC), Ilumya, Siliq, Stelara (IV or SC), or Taltz and | Yes | No |

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targeted synthetic DMARDs include: Xeljanz/XR, Olumiant, Rinvoq, or Otezla.]

[If yes, no further questions.]

- | | | | |
|----|--|-----|----|
| 11 | <p>Has the patient experienced ANY of the following within the prior 6 of treatment: A) myocardial infarction, B) unstable angina, C) stroke, D) transient ischemic attack (TIA), E) decompensated heart failure requiring hospitalization, or F) Class III or IV heart failure?
[If yes, no further questions.]</p> | Yes | No |
| 12 | <p>Does the provider attest that the patient does NOT have Mobitz type II second-degree or third degree atrioventricular (AV) block, sick sinus syndrome, or sinoatrial block, unless they have a functioning pacemaker?
[If no, no further questions.]</p> | Yes | No |
| 13 | <p>Has documentation been submitted to confirm that the patient has had treatment failure with AT LEAST 2 conventional systemic therapies for AT LEAST 3 months unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation.
[Note: Examples include azathioprine, 6-mercaptopurine, or methotrexate.]
[If no, no further questions.]</p> | Yes | No |
| 14 | <p>Has documentation been submitted to confirm that the patient has had a treatment failure with Budesonide for AT LEAST 3 months unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation.
[If no, no further questions.]</p> | Yes | No |
| 15 | <p>Has documentation been submitted to confirm that the patient has had a treatment failure with an adalimumab product (Hadlima, Simlandi, Yusimry, or adalimumab-adbm) for AT LEAST 3 months unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation.
[If no, no further questions.]</p> | Yes | No |
| 16 | <p>Has documentation been submitted to confirm that the patient has had a treatment failure with a preferred ustekinumab product (Yesintek, Pyzchiva, Steqeyma), for AT LEAST 3 months unless intolerant or contraindicated? ACTION REQUIRED: Submit supporting documentation.
[If no, no further questions.]</p> | Yes | No |
| 17 | <p>Is this medication being prescribed by, or in consultation with a gastroenterologist?
[If no, no further questions.]</p> | Yes | No |
| 18 | <p>Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication?
[Dosing: 2 mg once daily.]</p> | Yes | No |

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Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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