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 initial therapy or a continuation of therapy? [] Initial (If checked, go to 8) [] 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

Version 07.2026

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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 for 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	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 targeted synthetic DMARDs include: Xeljanz/XR, Olumiant, Rinvoq, or Otezla.] [If yes, no further questions.]	Yes	No
9	What is the diagnosis or indication? [] Ulcerative Colitis (If checked, go to 10) [] Other (If checked, no further questions)		

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10	Is the patient greater than or equal to 18 years of age or older? [If no, no further questions.]	Yes	No
11	Has the patient experienced ANY of the following within the prior 6 months 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.]	Yes	No
12	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.]	Yes	No
13	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.]	Yes	No
14	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.]	Yes	No
15	Has the patient been diagnosed with moderate to severe ulcerative colitis? [If no, skip to question 18.]	Yes	No
16	Has documentation been submitted to confirm that the patient has moderate to severe symptoms? ACTION REQUIRED: Submit supporting documentation. [Note: Examples include Mayo endoscopy sub-score greater than or equal to 2, greater than 6 bowel movement per day, greater than or equal to 4 bloody stools per day, hemoglobin less than 75% normal (males less than 10 g/dL, females less than 9 g/dL).] [If yes, skip to question 20.]	Yes	No
17	Has documentation been submitted to confirm that the patient has mildly active symptoms with poor prognosis factors for disease severity? ACTION REQUIRED: Submit supporting documentation. [Note: Examples include Mayo endoscopy sub-score of 3, extensive colitis, corticosteroid dependence (unable to taper after 3 months of continuous therapy), elevated C-reactive protein (CRP) greater than or equal to 10 mg/dL, low serum albumless than 3.4 mg/dL.] [If yes, skip to question 20.]	Yes	No
18	Has documentation been submitted to confirm that the patient has had a treatment	Yes	No

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Medicaid with a Heart

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	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.]		
19	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 yes, skip to question 21.] [If no, no further questions.]	Yes	No
20	Has documentation been submitted to confirm that the patient has had an intolerance, contraindication to, or failed treatment for at least 3 months with a preferred Infliximab product? ACTION REQUIRED: Submit supporting documentation. [Note: infusion dates and dosages required.] [If no, no further questions.]	Yes	No
21	Is this medication being prescribed by, or in consultation with a gastroenterologist? [If no, no further questions.]	Yes	No
22	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the indication? [Note: Dosing is 2 mg once daily.]	Yes	No

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.

Confidentiality: The information contained in this transmission is confidential and may be protected under

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