IOWA Health and Human Services

Request for Prior Authorization

SELECT NON-BIOLOGIC AGENTS FOR ULCERATIVE COLITIS

(PLEASE PRINT – ACCURACY IS IMPORTANT)

FAX Completed Form To
1 (800) 574-2515
Provider Help Desk
1 (877) 776-1567

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is required for select non-biologicals for ulcerative colitis (UC). Payment for non-preferred select non-biologicals for UC may be considered only for cases in which there is documentation of a previous trial and therapy failure with the preferred agent(s). Payment will be considered under the following conditions:

1) **Patient has a diagnosis of moderately to severely active UC; and**
2) **Request adheres to all FDA approved labeling for indication, including age, dosing, and contraindications; and**
3) **A documented trial and inadequate response to two preferred conventional therapies (immunomodulators) including aminosalicylates and azathioprine/6-mercaptopurine; and**
4) **A documented trial and inadequate response with a preferred biological DMARD; and**
5) **Will not be taken concomitantly with immunomodulators or biologic therapies.**

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Non-Preferred

☐ **Velsipity** ☐ **Zeposia**

Strength_____ **Dosage Instructions**_____ **Quantity**_____ **Days Supply**_____

Diagnosis:_____

Will medication be used in combination with immunomodulators or biologic therapies?
☐ Yes ☐ No

Trial Documentation:

Preferred Conventional Therapies (immunomodulators):

Trial 1: Name/Dose:_____ Trial Dates: _____
Failure reason:_____

Trial 2: Name/Dose:_____ Trial Dates: _____
Failure reason:_____

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Preferred Biological DMARD:

Name/Dose:_____ Trial Dates: _____

Failure reason:_____

Medical or contraindication reason to override trial requirements:_____

_____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Health and Human Services, that the member continues to be eligible for Medicaid.*