US Family Health Plan

Prior Authorization Request Form for

Etrasimod (Velsipity)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Prior authorization does not expire.

Step 1 **Please complete patient and physician information** (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

1. Provider is aware of all assessments, warnings, screening and monitoring precautions for the requested medication.	☐ Acknowledged Proceed to question **2**	
2. Does the patient have a diagnosis of moderate to severe active ulcerative colitis?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Is the patient greater than or equal to 18 years of age?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Humira is the Department of Defense's preferred targeted immunomodulatory biologic agent for ulcerative colitis. Has the patient tried Humira?	☐ Yes Proceed to question **5**	☐ No Proceed to question **7**
5. Has the patient had an inadequate response to Humira (adalimumab)?	☐ Yes Proceed to question **8**	☐ No Proceed to question **6**
6. Has the patient experienced an adverse reaction to Humira (adalimumab) that is not expected to occur with the requested agent?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
7. Does the patient have a contraindication to Humira (adalimumab)?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Is the patient receiving oral immunomodulatory or biologic therapies concomitantly?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **9**

9. Has the patient had an inadequate response to non-biologic systemic therapy? (For example - methotrexate, aminosalicylates [for example, sulfasalazine, mesalamine], corticosteroids, immunosuppressant's [for example, azathioprine], etc.)	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3

I certify the above is true to the best of my knowledge. Please sign and date:

Prescriber Signature _____ Date _____