TRICARE Prior Authorization Request Form for
etrasimod (Velsipity)

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HEALTH PLANS
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FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

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

[13 Dec 2023]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: