

**Request for Prior Authorization
SELECT NON-BIOLOGIC AGENTS
FOR ULCERATIVE COLITIS**

(PLEASE PRINT – ACCURACY IS IMPORTANT)

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
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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 Human Services, that the member continues to be eligible for Medicaid.*