SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Non-Preferred Adalimumab Products (Pharmacy)

Drug Requested: (Select drug requested below)

❑ **Abrilada®** (adalimumab-afzb)	❑ **adalimumab-aacf** (generic for Idacio®)	❑ **adalimumab-aaty** (generic for Yuflyma®)
❑ **adalimumab-adaz** (generic for Hyrimoz®)	❑ **adalimumab-adbm** (Quallent)	❑ **adalimumab-fkjp** (generic for Hulio®)
❑ **Adalimumab-ryvk** (generic for Simlandi®)	❑ **Amjevita®** (adalimumab-atto)	❑ **Cyltezo®** (adalimumab-adbm
❑ **Hulio®** (adalimumab-fkjp)	❑ **Humira®** (adalimumab) *see additional criteria for approval	❑ **Hyrimoz®** (adalimumab-adaz)
❑ **Idacio®** (adalimumab-aacf)	❑ **Simlandi®** (adalimumab-ryvk)	❑ **Yuflyma®** (adalimumab-aaty)
❑ **Yusimry®** (adalimumab-aqvh)		

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

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NOTE: The Health Plan considers the use of concomitant therapy with more than one biologic immunomodulator (e.g., Dupixent, Entyvio, Humira, Rinvoq, Stelara) prescribed for the same or different indications to be experimental and investigational. Safety and efficacy of these combinations has **NOT** been established and will **NOT** be permitted.

Diagnosis/ Member must meet FDA approved age and indication for coverage	Recommended Dose/ Quantity Limit
Rheumatoid Arthritis/Juvenile Idiopathic Arthritis/Psoriatic Arthritis/Ankylosing Spondylitis	• Quantity Limit: • Two, syringes/pen per 28 days.

Adult Crohn's Disease/Ulcerative Colitis	• Quantity Limit:
	  • Six, syringes/pen in the initial 28 days.
	  • Two, syringes/pen per 28 days after induction period.

Pediatric Crohn's Disease	• **37lbs to < 88lbs:**
	  • Quantity limit Initial month:
	  • One, syringe/pen 20mg, 40mg or 80mg.
	• Maintenance
	  • Two, syringes/pen 20mg per 28 days.
	• **≥ 88lbs:**
	  • Quantity limit Initial month:
	  • One, syringe/pen 40mg, 80mg or 160mg.
	• Maintenance:
	  • Begin a maintenance dose of Two, syringes/pen 40mg every 28 days.

Plaque Psoriasis	• Quantity Limit:
	  • Four, syringes/pen in the initial 28 days.
	  • Two, syringes/pen per 28 days after induction period.

Hidradenitis Suppurativa Adults	• 160 mg day 1, followed by 80 mg day 15 (6 syringes/28 days) for induction period, thereafter 40 mg once a week starting day 29 (4 syringes/28 days)

Hidradenitis Suppurativa Children 12-17 years old	• **30kg to 59kg:**
	  • Quantity limit Initial:
	  • 80mg on day one.
	• Maintenance
	  • 40 mg once every other week starting on day 29.
	• **≥ 60kg:**
	  • Quantity limit Initial:
	  • 160 mg day 1, followed by 80 mg day 15(6 syringes/28 days) for induction period.
	• Maintenance:
	  • 40 mg once a week starting on day 29 (4 syringes/28 days).

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Diagnosis	Recommended Dose/ Quantity Limit

Uveitis	**Adults:**
	• Quantity limit Initial:
	  • Four syringes in the initial 28 days.
	• Maintenance
	  • Two syringes/ pens per 28 days after induction period.
	Children 2-17 years old:
	• **10kg-14kg:**
	  • Quantity limit:
	  • 10 mg every other week
	• **15kg-29kg:**
	  • Quantity limit:
	  • 20 mg every other week
	• **30kg:**
	  • Quantity limit:
	  • 40 mg every other week

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

❑ Diagnosis: Moderate-to-Severe Rheumatoid Arthritis

- ❑ Member has a diagnosis of moderate-to-severe **rheumatoid arthritis**
- ❑ Trial and failure of **BOTH** of the **PREFERRED** drugs below:

❑ adalimumab-adbm (Boehringer Ingelheim) **OR** Hadlima® (adalimumab-bwwd)	❑ Enbrel®

❑ Diagnosis: Moderate-to-Severe Active Polyarticular Juvenile Idiopathic Arthritis

- ❑ Member has a diagnosis of moderate-to-severe active polyarticular **juvenile idiopathic arthritis**
- ❑ Trial and failure of **BOTH** of the **PREFERRED** drugs below:

❑ adalimumab-adbm (Boehringer Ingelheim) **OR** Hadlima® (adalimumab-bwwd)	❑ Enbrel®

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❑ Diagnosis: Active Psoriatic Arthritis

- ❑ Member has a diagnosis of active **psoriatic arthritis**
- ❑ Trial and failure of **TWO (2)** of the **PREFERRED** drugs below:

❑ adalimumab-adbm (Boehringer Ingelheim) **OR** Hadlima® (adalimumab-bwwd)	❑ Enbrel®	❑ Pyzchiva® syringe/vial **OR** Starjemza™ (Requires trial and failure of a preferred TNF-alpha inhibitor)

❑ Diagnosis: Active Ankylosing Spondylitis

- ❑ Member has a diagnosis of active **ankylosing spondylitis**
- ❑ Trial and failure of **BOTH** of the **PREFERRED** drugs below:

❑ adalimumab-adbm (Boehringer Ingelheim) **OR** Hadlima® (adalimumab-bwwd)	❑ Enbrel®

❑ Diagnosis: Moderate-to-Severe Active Crohn's Disease (CD)

- ❑ Member has a diagnosis of moderate-to-severe active **Crohn's disease**
- ❑ Member has tried and failed **BOTH** of the **PREFERRED** drugs below:

❑ adalimumab-adbm (Boehringer Ingelheim) **OR** Hadlima® (adalimumab-bwwd)	❑ Pyzchiva® syringe/vial **OR** Starjemza™ (Requires trial and failure of a preferred TNF-alpha inhibitor)

❑ Diagnosis: Moderate-to-Severe Ulcerative Colitis (UC)

- ❑ Member has a diagnosis of moderate-to-severe active **Ulcerative Colitis**
- ❑ Member has tried and failed **BOTH** of the **PREFERRED** drugs below:

❑ adalimumab-adbm (Boehringer Ingelheim) **OR** Hadlima® (adalimumab-bwwd)	❑ Pyzchiva® syringe/vial **OR** Starjemza™ (Requires trial and failure of a preferred TNF-alpha inhibitor)

❑ Diagnosis: Moderate-to-Severe Chronic Plaque Psoriasis

- ❑ Member has a diagnosis of moderate-to-severe chronic **plaque psoriasis**
- ❑ Trial and failure of **TWO (2)** of the **PREFERRED** drugs below:

❑ adalimumab-adbm (Boehringer Ingelheim) **OR** Hadlima® (adalimumab-bwwd)	❑ Enbrel®	❑ Pyzchiva® syringe/vial **OR** Starjemza™ (Requires trial and failure of a preferred TNF-alpha inhibitor)

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❑ Diagnosis: Moderate-to-Severe Hidradenitis Suppurativa (HS)

- ❑ Member has a diagnosis of moderate-to-severe **hidradenitis suppurativa**
- ❑ Trial and failure of adalimumab-adbm (Boehringer Ingelheim) **OR** Hadlima® (adalimumab-bwwd)

❑ Diagnosis: Uveitis (UV)

- ❑ Member has a diagnosis of **Uveitis**
- ❑ Member has trial and failure of adalimumab-adbm (Boehringer Ingelheim) **OR** Hadlima® (adalimumab-bwwd)

❑ For Brand Humira approval

- ❑ Member has trial and failure of **TWO** preferred biosimilar agents for Humira
- ❑ **FDA Medwatch form must be completed** for **BOTH** preferred adalimumab biosimilar products (adalimumab-adbm [Boehringer Ingelheim] **AND** Hadlima® [adalimumab-bwwd]) and a copy of submitted MedWatch form must be attached for approval consideration

❑ MEDICAL NECESSITY: Provide clinical evidence that supports the use of the requested medication

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Medication being provided by Specialty Pharmacy - PropriumRx

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.

<u>Previous therapies will be verified through pharmacy paid claims or submitted chart notes.</u>