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 information provided is not complete, correct, or legible, authorization will be delayed.**

Drug Requested: Amjevita™/ Amjevita Autoinjector™(adalimumab) **(Pharmacy)**

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:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

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

Diagnosis: _____ **ICD Code:** _____

Weight: _____ **Date:** _____

NOTE: Sentara Community 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.

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. **Check the diagnosis below that applies.**

❑ **Diagnosis: Moderate-to-Severe Rheumatoid Arthritis**
Dosing: SubQ: 40 mg every other week

- ❑ Member has a diagnosis of moderate-to-severe **rheumatoid arthritis**
- ❑ Prescribed by or in consultation with a **Rheumatologist**
- ❑ Member has tried and failed at least **ONE DMARD** therapy (such as hydroxychloroquine, leflunomide, methotrexate, sulfasalazine)

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- ❑ Member has tried and failed at least **TWO** of the **PREFERRED** drugs below:

❑ Humira®	❑ Enbrel®	❑ Infliximab

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

Dosing: SubQ: 40 mg every other week

- ❑ Member has a diagnosis of moderate-to-severe active polyarticular **juvenile idiopathic arthritis**
- ❑ Prescribed by or in consultation with a **Rheumatologist**
- ❑ Member is ≥ 2 years of age
- ❑ Member has tried and failed at least **ONE DMARD** therapy (e.g.,hydroxychloroquine, leflunomide, methotrexate, sulfasalazine)
- ❑ Member has tried and failed at least **TWO** of the **PREFERRED** drugs below:

❑ Humira®	❑ Enbrel®	❑ Infliximab

❑ Diagnosis: Active Psoriatic Arthritis

Dosing: SubQ: 40 mg every other week

- ❑ Member has a diagnosis of active **psoriatic arthritis**
- ❑ Prescribed by or in consultation with a **Rheumatologist**
- ❑ Member has tried and failed at least **ONE DMARD** therapy (e.g.,hydroxychloroquine, leflunomide, methotrexate, sulfasalazine)
- ❑ Member has tried and failed at least **TWO** of the **PREFERRED** drugs below:

❑ Humira®	❑ Enbrel®	❑ Infliximab

❑ Diagnosis: Active Ankylosing Spondylitis

Dosing: SubQ: 40 mg every other week.

- ❑ Member has a diagnosis of active **ankylosing spondylitis**
- ❑ Prescribed by or in consultation with a **Rheumatologist**
- ❑ Member tried and failed, has a contraindication, or intolerance to **TWO** NSAIDs
- ❑ Member has tried and failed at least **TWO** of the **PREFERRED** drugs below:

❑ Humira®	❑ Enbrel®	❑ Infliximab

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

Dosing: SubQ: Initial: 160 mg (given on day 1 or split and given over 2 consecutive days); then 80 mg 2 weeks later (day 15). **Maintenance:** 40 mg every week beginning day 29

- ❑ Member is ≥ 12 years of age and has a diagnosis of moderate-to-severe **hidradenitis suppurativa**
- ❑ Prescribed by or in consultation with a **Dermatologist**
- ❑ Trial and failure of, contraindication, or adverse reaction to methotrexate
- ❑ Member has tried and failed at least **TWO** of the **PREFERRED** drugs below:

❑ Humira®	❑ Enbrel®	❑ Infliximab

❑ Diagnosis: Moderate-to-Severe Chronic Plaque Psoriasis

Dosing: SubQ: Initial: 80 mg as a single dose. **Maintenance:** 40 mg every other week beginning 1 week after initial dose.

- ❑ Member has a diagnosis of moderate-to-severe chronic **plaque psoriasis**
- ❑ Prescribed by or in consultation with a **Dermatologist**
- ❑ Member has tried and failed at least **ONE DMARD** therapy (e.g., hydroxychloroquine, leflunomide, methotrexate, sulfasalazine)
- ❑ Member has tried and failed at least **TWO** of the **PREFERRED** drugs below**:**

❑ Humira®	❑ Enbrel®	❑ Infliximab

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

Dosing: SubQ: Initial: 160 mg (given on day 1 or split and given over 2 consecutive days); then 80 mg 2 weeks later (day 15). **Maintenance:** 40 mg every other week beginning day 29.

- ❑ Member is ≥ 6 years of age and has a diagnosis of moderate-to-severe active **Crohn's disease**
- ❑ Prescribed by or in consultation with a **Gastroenterologist**
- ❑ Member has tried and failed at least **ONE DMARD** therapy (e.g.,5-aminosalicylates (balsalazide, olsalazine, sulfasalazine, oral mesalamine (Apriso, Asacol/HD, Delzicol, Lialda, Pentasa)
- ❑ Member has tried and failed at least **TWO** of the **PREFERRED** drugs below**:**

❑ Humira®	❑ Enbrel®	❑ Infliximab

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

Dosing: SubQ: Initial: 160 mg (given on day 1 OR split and given over 2 consecutive days); then 80 mg 2 weeks later (day 15). **Maintenance:** 40 mg every other week beginning day 29.

- ❑ Member is ≥ 5 years of age and has a diagnosis of moderate-to-severe **ulcerative colitis**
- ❑ Prescribed by or in consultation with a **Gastroenterologist**

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- ❑ Member has tried and failed at least **ONE DMARD** therapy (e.g.,5-aminosalicylates (balsalazide, olsalazine, sulfasalazine, oral mesalamine (Apriso, Asacol/HD, Delzicol, Lialda, Pentasa)
- ❑ Member has tried and failed at least **TWO** of the **PREFERRED** drugs below**:**

❑ Humira®	❑ Enbrel®	❑ Infliximab

❑ **Diagnosis: Uveitis (non-infectious intermediate, posterior, and panuveitis)**

Dosing: SubQ: Initial: 80 mg as a single dose. Maintenance: 40 mg every other week beginning 1 week after initial dose.

- ❑ Member is ≥ 2 years of age and has a diagnosis of Uveitis **(check box below for diagnosis that applies)**:

❑ Chronic	❑ Treatment-refractory
❑ Recurrent	❑ Vision-threatening disease

- ❑ Prescribed by or in consultation with an **Ophthalmologist or Rheumatologist**
- ❑ Member has tried and failed at least **ONE DMARD** therapy (e.g., hydroxychloroquine, leflunomide, methotrexate, sulfasalazine)
- ❑ Member has tried and failed at least **TWO** of the **PREFERRED** drugs below**:**

❑ Humira®	❑ Enbrel®	❑ Infliximab

Medication being provided by a Specialty Pharmacy – Proprium Rx

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

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****