

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 Ustekinumab products (PHARMACY BENEFIT ONLY)
(ustekinumab SQ therapy is Self-Administered by member)

Drug Requested: (Select drug below)

| PREFERRED | | |
|--|---|--|
| <input type="checkbox"/> Pyzchiva[®] (ustekinumab-ttwe) syringe/vial (Requires trial and failure of a preferred TNF-alpha inhibitor) | <input type="checkbox"/> Starjemza[™] (ustekinumab-hmny) (Requires trial and failure of a preferred TNF-alpha inhibitor) | |
| NON-PREFERRED | | |
| <input type="checkbox"/> Imuldosa[™] (ustekinumab-srlf) | <input type="checkbox"/> Otulfi[®] (ustekinumab-aauz) | <input type="checkbox"/> Pyzchiva[®] (ustekinumab-ttwe) Auto-Injector |
| <input type="checkbox"/> Selarsdi[®] (ustekinumab-aekn) | <input type="checkbox"/> Stelara[®] (ustekinumab) <small>*see additional criteria for approval</small> | <input type="checkbox"/> Steqeyma[®] (ustekinumab-stba) |
| <input type="checkbox"/> ustekinumab (generic Stelara [®]) | <input type="checkbox"/> ustekinumab-aekn (generic Selarsdi [®]) | <input type="checkbox"/> ustekinumab-ttwe (generic Pyzchiva [®]) |
| <input type="checkbox"/> Wezlana[™] (ustekinumab-kfce) | <input type="checkbox"/> Yesintek[™] (ustekinumab-kfce) | |

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 #: _____

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PA Non-Preferred Ustekinumab Products (Medicaid)

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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:** _____

Recommended Dose:

| Indication | Dosage: |
|---|--|
| Adults with Moderate to Severe Chronic Plaque Psoriasis | Weight <ul style="list-style-type: none"> • Less than or = 100 kg Initial (two 45 mg prefilled syringe/ 28 days) then continue with one 45 mg prefilled syringe/84 days • Great than 100 kg Two 90 mg administered prefilled syringe/ 28 days then, one 90 mg administered prefilled syringe/ 84 days |
| Pediatric patients (6 years or older) with Moderate to Severe Chronic Plaque Psoriasis | <ul style="list-style-type: none"> • <60 kg (0.75 mg/kg): Initial (two 45 mg prefilled syringe/28days) then one 45mg/84 days • ≥ 60 to ≤ 100 kg: Initial (two 45 mg prefilled syringe/ 28 days) then one 45/ 84 days • >100 kg: two 90 mg administered prefilled syringe/ 28 days, then one 90 mg/84 days |
| Active Psoriatic Arthritis | <ul style="list-style-type: none"> • <60 kg (0.75 mg/kg): Initial (two 45 mg prefilled syringe/28days) then one 45mg/84 days • ≥ 60 to ≤ 100 kg: Initial (two 45 mg prefilled syringe/ 28 days) then one 45/ 84 days • >100 kg: two 90 mg administered prefilled syringe/ 28 days, then one 90 mg/84 days |
| Moderately to Severe Active Crohn's Disease | <ul style="list-style-type: none"> • A single intravenous infusion using weight-based dosing • Up to 55 kg 260 mg (2 vials) • Greater than 55 kg to 85 kg 390 mg (3 vials) • Greater than 85 kg 520 mg (4 vials) • After initial IV dose: 90mg syringe every 56 days |
| Adult patient with Moderately to Severely Active Ulcerative Colitis | <ul style="list-style-type: none"> • A single intravenous infusion using weight-based dosing • Up to 55 kg 260 mg (2 vials) • Greater than 55 kg to 85 kg 390 mg (3 vials) • Greater than 85 kg 520 mg (4 vials) • After initial IV dose: 90mg syringe every 56 days |

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CLINICAL CRITERIAL: 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: Check below diagnosis that applies to qualify for approval or authorization may be delayed.

Diagnosis: Adults with Active Psoriatic Arthritis

- Member has a diagnosis of moderate to severe psoriatic arthritis
- Member has tried and failed **ONE (1)** of the preferred drugs below:

| | |
|--|--|
| <input type="checkbox"/> adalimumab-adbm (Boehringer Ingelheim) OR Hadlima [®] (adalimumab-bwwd) | <input type="checkbox"/> Enbrel [®] |
|--|--|

- Member has tried and failed Pyzchiva[®] syringe/vial **OR** Starjemza[™] (requires trial and failure of a preferred TNF-alpha inhibitor)

Diagnosis: Pediatric members (6 years and older) with psoriatic arthritis

- Member is 6 years or older
- Member has a diagnosis of psoriatic arthritis
- Member has tried and failed **ONE (1)** of the preferred drugs below:

| | |
|--|--|
| <input type="checkbox"/> adalimumab-adbm (Boehringer Ingelheim) OR Hadlima [®] (adalimumab-bwwd) | <input type="checkbox"/> Enbrel [®] |
|--|--|

- Member has tried and failed Pyzchiva[®] syringe/vial **OR** Starjemza[™] (requires trial and failure of a preferred TNF-alpha inhibitor)

Diagnosis: Moderate to Severe Chronic Plaque Psoriasis

- Member is 6 years or older
- Member has a diagnosis of moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy
- Member has tried and failed **ONE (1)** of the preferred drugs below:

| | |
|--|--|
| <input type="checkbox"/> adalimumab-adbm (Boehringer Ingelheim) OR Hadlima [®] (adalimumab-bwwd) | <input type="checkbox"/> Enbrel [®] |
|--|--|

- Member has tried and failed Pyzchiva[®] syringe/vial **OR** Starjemza[™] (requires trial and failure of a preferred TNF-alpha inhibitor)

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Diagnosis: Ulcerative Colitis

- Member has a diagnosis of moderate to severe active disease
- Trial and failure of **BOTH** of the preferred drugs below:

| | |
|--|--|
| <input type="checkbox"/> adalimumab-adbm (Boehringer Ingelheim) OR Hadlima [®] (adalimumab-bwwd) | <input type="checkbox"/> Pyzchiva [®] syringe/vial OR Starjemza [™] (Requires trial and failure of a preferred TNF-alpha inhibitor) |
|--|--|

Diagnosis: Crohn's Disease

- Member has a diagnosis of moderate to severe active disease
- Trial and failure of **BOTH** of the preferred drugs below:

| | |
|--|--|
| <input type="checkbox"/> adalimumab-adbm (Boehringer Ingelheim) OR Hadlima [®] (adalimumab-bwwd) | <input type="checkbox"/> Pyzchiva [®] syringe/vial OR Starjemza [™] (Requires trial and failure of a preferred TNF-alpha inhibitor) |
|--|--|

For Brand Stelara approval

- Member has trial and failure of **ONE** preferred biosimilar agents for Humira:
 - adalimumab-adbm (Boehringer Ingelheim)
 - Hadlima[®] (adalimumab-bwwd)
- Member has tried and failed Pyzchiva[®] syringe/vial **AND** Starjemza[™]
- FDA Medwatch** form must be completed for the preferred ustekinumab biosimilar product, Pyzchiva[®] syringe/vial **AND** Starjemza[™] **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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Induction Dose (If required) – Single IV induction dose

Authorization Criteria: To be reviewed for one-time approval under the medical benefit

- Medication will be used as induction therapy
- Medication being provided by:
 - Location/site of drug administration: _____
NPI or DEA # of administering location: _____
- Select **ONE** of the following one-time doses to be administered based on member's weight
 - ≤55 kg: 260 mg as single dose; 260 mg = 260 billable units
 - >55 kg to 85 kg: 390 mg as single dose; 390 mg = 390 billable units
 - >85 kg: 520 mg as single dose; 520 mg = 520 mg billable units

Medication being provided by Specialty Pharmacy - PropriumRx

*****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.****