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.**

Drug Requested: Non-Preferred Ustekinumab products (PHARMACY BENEFIT ONLY)
(ustekinumab SQ therapy is Self-Administered by member)

PREFERRED		
❑ **Pyzchiva®** (ustekinumab-ttwe) **syringe/vial** (Requires trial and failure of a preferred TNF-alpha inhibitor)		
NON-PREFERRED		
❑ **Imuldosa™** (ustekinumab-srlf)	❑ **Otulfi®** (ustekinumab-aauz)	❑ **Selarsdi®** (ustekinumab-aekn)
❑ **Steqeyma®** (ustekinumab-stba)	❑ **ustekinumab** (generic Stelara®)	❑ **ustekinumab-aekn** (generic Selarsdi®)
❑ **ustekinumab-ttwe** (generic Pyzchiva®)	❑ **Wezlana™** (ustekinumab-kfce)	❑ **Yesintek™** (ustekinumab-kfce)
❑ **Stelara®** (ustekinumab) *see additional criteria for approval		

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 #: _____

(Continued on next page)

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** • 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	• <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	• <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	• 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	• 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

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.

(Continued on next page)

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:

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

- ❒ Member has tried and failed Pyzchiva® syringe/vial (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:

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

- ❒ Member has tried and failed Pyzchiva® syringe/vial (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:

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

- ❒ Member has tried and failed Pyzchiva® syringe/vial (requires trial and failure of a preferred TNF-alpha inhibitor)

❑ Diagnosis: Ulcerative Colitis

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

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

(Continued on next page)

❑ Diagnosis: Crohn's Disease

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

❑ adalimumab-adbm (Boehringer Ingelheim) OR Hadlima® (adalimumab-bwwd)	❑ Pyzchiva® syringe/vial (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
- ❑ **FDA Medwatch** form must be completed for the preferred ustekinumab biosimilar product, Pyzchiva® syringe/vial **and a copy of submitted MedWatch form must be attached for approval consideration.**

❑ 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.*

REVISED/UPDATED/REFORMATTED: ~~8/1/2017; 8/31/2017; 12/27/2017; 8/30/2018; 11/19/2018; (Rev) 4/6/2019; 1/6/2020; 6/18/2020; 12/21/2020; 7/19/2021; 8/10/2021; 7/11/2022; 6/26/2023; 9/26/2023; 3/25/2025; 10/17/2025;~~ **12/13/2025**