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.**

Preferred Cytokine and CAM antagonists (Pharmacy)

Drug Requested: (select the drug below that applies)

PREFERRED	
❑ **adalimumab-adbm** (Boehringer Ingelheim) **OR Hadlima®** (adalimumab-bwwd)	❑ **Enbrel®** (etanercept)
❑ **Pyzchiva syringe/vial®*** *(may be approved after trial and failure of a preferred TNF-alpha inhibitor [adalimumab-adbm or Enbrel])	❑ **Starjemza™** (ustekinumab-hmny)* *(may be approved after trial and failure of a preferred TNF-alpha inhibitor [adalimumab-adbm or Enbrel])

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:** _____

Requested Medication is ONE of the following:

- ❑ New Start
- ❑ Continuation of therapy – Provide therapy start date:_____

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DIAGNOSIS	Recommended Dose
❑ **Ankylosing Spondylitis (AS)**	• **Enbrel:** Four 50mg syringes, OR eight 25mg syringes per 28 days • **adalimumab:** Two syringes/pens per 28 days

❑ **Crohn's Disease (CD)**	• **adalimumab**: 160 mg day 1, followed by 80 mg day 15 (6 syringes/28 days) for induction period, thereafter 40 mg every other week starting day 29 (2 syringes/28 days)
	• **Pyzchiva/Starjemza**: 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 the initial IV dose: one 90 mg syringe every 56 days

❑ **Hidradenitis Suppurativa (HS)**	• **adalimumab:** 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) • **adalimumab:** >60 kg or more: 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) • **adalimumab:** 30-59 kg: 80 mg on day 1, then maintenance treatment of 40 mg once every other week starting on Day 29
❑ **Juvenile Idiopathic Arthritis (JIA)**	• **Enbrel:** Four 50mg syringes, OR eight 25mg syringes per 28 days • **adalimumab:** Two syringes/pens per 28 days

❑ **Pediatric Crohn's Disease (CD)**	• **adalimumab:**
	  • 37 lbs to < 88lbs:
	  • Initial month
	  • One syringes/pen 80mg
	  • One syringes/pen 40mg
	  • One syringes/pen 20mg
	  • Maintenance
	  • Two syringes/pens 20mg per 28 days.
	  • ≥ 88 lbs:
	  • Initial month
	  • One syringes/pen 160mg
	  • One syringes/pen 80mg
	  • One syringes/pen 40mg
	  • Maintenance
	  • Two syringes/pens 40mg per 28 days

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DIAGNOSIS	Recommended Dose

❑ **Plaque Psoriasis (PsO)**	• **Enbrel:** Eight, 50mg syringes per 28 days for the initial 3 months
	• **Enbrel:** Four, 50mg syringes per 28 days after induction period
	• **adalimumab:** Four syringes/pens in the initial 28 days
	• **adalimumab:** Two syringes/pens per 28 days after induction period
	• **Pyzchiva/Starjemza:** 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 the initial IV dose: one 90 mg syringe every 56 days
	• **Pyzchiva/Starjemza**: Children 5 and older:
	  • Administer at Weeks 0 and 4 then every 12 weeks thereafter
	  • < 60 kg: 0.75 mg/kg
	  • Initial: Two 45mg prefilled syringes/28 days then continue with one 45mg prefilled syringe/84 days
	  • 60 to 100 kg =
	  • Initial: Two 45mg prefilled syringes/28 days then continue with one 45mg prefilled syringe/84 days
	  • Greater than 100 kg:
	  • Initial: Two 90 mg prefilled syringes/28 days then one 90 mg prefilled syringe/84 days

❑ **Polyarticular Juvenile Idiopathic Arthritis (pJIA)**	• **Enbrel:** Four, 50mg syringes, OR eight 25mg syringes per 28 days

❑ **Psoriatic Arthritis (PsA)**	• **Enbrel:** Four 50mg syringes, OR eight 25mg syringes per 28 days
	• **adalimumab:** Two syringes/pens per 28 days
	• **Pyzchiva/Starjemza:** two 45mg prefilled syringe/28 days; then continue with one 45mg prefilled syringe/84 days
	• **Pyzchiva/Starjemza:** Children 6 and older:
	  • Administer at Weeks 0 and 4 then every 12 weeks thereafter
	  • < 60 kg: 0.75 mg/kg
	  • Initial: Two 45mg prefilled syringes/28 days then continue with one 45mg prefilled syringe/84 days
	  • 60 to 100 kg =
	  • Initial: Two 45mg prefilled syringes/28 days then
	  • prefilled syringe/84 days
	  • Greater than 100 kg:
	  • Initial: Two 90 mg prefilled syringes/28 days then one 90 mg prefilled syringe/84 days

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DIAGNOSIS	Recommended Dose
❑ **Rheumatoid Arthritis (RA)**	• **Enbrel:** Four 50mg syringes, OR eight 25mg syringes per 28 days • **adalimumab:** Two syringes/pens per 28 days

❑ **Ulcerative Colitis (UC)**	• **adalimumab:** Six syringes/pens in the initial 28 days
	• **adalimumab:** Two syringes/pens per 28 days after induction period
	• **Pyzchiva/Starjemza:** 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 the initial IV dose: one 90 mg syringe every 56 days

❑ **Uveitis (UV)**	• **adalimumab:** Adults: (Four syringes in the initial 28 days), then Two syringes/ pens per 28 days after induction period.
	• **adalimumab**: Children 2-17 years old:
	  • 30kg or more: 40mg every other week
	  • 15-29kg: 20mg every other week
	  • 10-14kg: 10mg 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.

Authorization Length : 12 months

Member must meet FDA approved age and indication for coverage

❑ Ankylosing Spondylitis (AS) Dosing: _____	❑ Crohn's Disease (CD) Dosing: _____
❑ Hidradenitis Suppurativa (HS) Dosing: _____	❑ Juvenile Idiopathic Arthritis (JIA) Dosing: _____
❑ Plaque Psoriasis (Ps) Dosing: _____	❑ Psoriatic Arthritis (PsA) Dosing: _____
❑ Rheumatoid Arthritis (RA) Dosing: _____	❑ Ulcerative Colitis (UC) Dosing: _____
❑ Uveitis (UV) Dosing: _____	❑ Polyarticular Juvenile Idiopathic Dosing: _____
❑ Other: _____ Dosing: _____	

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- ❑ **Pyzchiva syringe/vials and Starjemza™ requests:** Pyzchiva® and Starjemza™ are the preferred ustekinumab products and may be approved after trial and failure of a preferred TNF-alpha inhibitor (All other ustekinumab products require routine PDL edits including a trial and failure of Pyzchiva® or Starjemza™).
  - ❑ Member has tried and failed **ONE (1)** of the preferred drugs below:
    - ❑ adalimumab-adbm (Boehringer Ingelheim)
    - ❑ Hadlima® (adalimumab-bwwd)
    - ❑ Enbrel®

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: ~~6/2/2025; 6/20/2025, 12/12/2025; 1/29/2026, 2/23/2026; 3/20/2026;~~ **9/30/2026**