

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	
<input type="checkbox"/> adalimumab-adbm (Boehringer Ingelheim) OR Hadlima [®] (adalimumab-bwwd)	<input type="checkbox"/> Enbrel [®] (etanercept)
<input type="checkbox"/> Pyzchiva syringe/vial ^{®*} *(may be approved after trial and failure of a preferred TNF-alpha inhibitor [adalimumab-adbm or Enbrel])	<input type="checkbox"/> 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: _____

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PA Preferred Cytokine and CAM Antagonists (Preferred) (Medicaid)
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DIAGNOSIS	Recommended Dose
<p>☐ Ankylosing Spondylitis (AS)</p>	<ul style="list-style-type: none"> • Enbrel: Four 50mg syringes, OR eight 25mg syringes per 28 days • adalimumab: Two syringes/pens per 28 days
<p>☐ Crohn’s Disease (CD)</p>	<ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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
<p>☐ Hidradenitis Suppurativa (HS)</p>	<ul style="list-style-type: none"> • 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
<p>☐ Juvenile Idiopathic Arthritis (JIA)</p>	<ul style="list-style-type: none"> • Enbrel: Four 50mg syringes, OR eight 25mg syringes per 28 days • adalimumab: Two syringes/pens per 28 days
<p>☐ Pediatric Crohn’s Disease (CD)</p>	<ul style="list-style-type: none"> • adalimumab: <ul style="list-style-type: none"> • 37 lbs to < 88lbs: <ul style="list-style-type: none"> • Initial month <ul style="list-style-type: none"> • One syringes/pen 80mg • One syringes/pen 40mg • One syringes/pen 20mg • Maintenance <ul style="list-style-type: none"> • Two syringes/pens 20mg per 28 days. • ≥ 88 lbs: <ul style="list-style-type: none"> • Initial month <ul style="list-style-type: none"> • One syringes/pen 160mg • One syringes/pen 80mg • One syringes/pen 40mg • Maintenance <ul style="list-style-type: none"> • Two syringes/pens 40mg per 28 days

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PA Preferred Cytokine and CAM Antagonists (Preferred) (Medicaid)
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DIAGNOSIS	Recommended Dose
<p>❑ Plaque Psoriasis (PsO)</p>	<ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • Administer at Weeks 0 and 4 then every 12 weeks thereafter • < 60 kg: 0.75 mg/kg <ul style="list-style-type: none"> • Initial: Two 45mg prefilled syringes/28 days then continue with one 45mg prefilled syringe/84 days • 60 to 100 kg = <ul style="list-style-type: none"> • Initial: Two 45mg prefilled syringes/28 days then continue with one 45mg prefilled syringe/84 days • Greater than 100 kg: <ul style="list-style-type: none"> • Initial: Two 90 mg prefilled syringes/28 days then one 90 mg prefilled syringe/84 days
<p>❑ Polyarticular Juvenile Idiopathic Arthritis (pJIA)</p>	<ul style="list-style-type: none"> • Enbrel: Four, 50mg syringes, OR eight 25mg syringes per 28 days
<p>❑ Psoriatic Arthritis (PsA)</p>	<ul style="list-style-type: none"> • Enbrel: Four 50mg 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: <ul style="list-style-type: none"> • Administer at Weeks 0 and 4 then every 12 weeks thereafter • < 60 kg: 0.75 mg/kg <ul style="list-style-type: none"> • Initial: Two 45mg prefilled syringes/28 days then continue with one 45mg prefilled syringe/84 days • 60 to 100 kg = <ul style="list-style-type: none"> • Initial: Two 45mg prefilled syringes/28 days then prefilled syringe/84 days • Greater than 100 kg: <ul style="list-style-type: none"> • Initial: Two 90 mg prefilled syringes/28 days then one 90 mg prefilled syringe/84 days

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PA Preferred Cytokine and CAM Antagonists (Preferred) (Medicaid)
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DIAGNOSIS	Recommended Dose
<input type="checkbox"/> Rheumatoid Arthritis (RA)	<ul style="list-style-type: none"> • Enbrel: Four 50mg syringes, OR eight 25mg syringes per 28 days • adalimumab: Two syringes/pens per 28 days
<input type="checkbox"/> Ulcerative Colitis (UC)	<ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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
<input type="checkbox"/> Uveitis (UV)	<ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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.

Member must meet FDA approved age and indication for coverage

<input type="checkbox"/> Ankylosing Spondylitis (AS) Dosing: _____	<input type="checkbox"/> Crohn's Disease (CD) Dosing: _____
<input type="checkbox"/> Hidradenitis Suppurativa (HS) Dosing: _____	<input type="checkbox"/> Juvenile Idiopathic Arthritis (JIA) Dosing: _____
<input type="checkbox"/> Plaque Psoriasis (Ps) Dosing: _____	<input type="checkbox"/> Psoriatic Arthritis (PsA) Dosing: _____
<input type="checkbox"/> Rheumatoid Arthritis (RA) Dosing: _____	<input type="checkbox"/> Ulcerative Colitis (UC) Dosing: _____
<input type="checkbox"/> Uveitis (UV) Dosing: _____	<input type="checkbox"/> Polyarticular Juvenile Idiopathic Dosing: _____
<input type="checkbox"/> 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.****