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		
❑ **Humira®** (adalimumab)	❑ **Enbrel®** (etanercept)	❑ **Infliximab*** *(Refer to infliximab products PA form)

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:** _____

DIAGNOSIS	Recommended Dose
❑ **Ankylosing Spondylitis (AS)**	• **Enbrel:** Four 50mg syringes, OR eight 25mg syringes per 28 days • **Humira:** Two syringes/pens per 28 days
❑ **Crohn's Disease (CD)**	• **Humira:** 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)

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DIAGNOSIS	Recommended Dose
❑ **Hidradenitis Suppurativa (HS)**	• **Humira:** 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) • **Humira:** >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) • **Humira:** 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 • **Humira:** Two syringes/pens per 28 days

❑ **Pediatric Crohn's Disease (CD)**	• **Humira:**
	  • 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

❑ **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 • **Humira:** Four syringes/pens in the initial 28 days • **Humira:** Two syringes/pens per 28 days after induction period
❑ **Polyarticular Juvenile Idiopathic Arthritis (pJIA)**	• **Enbrel:** Four, 50mg syringes, OR eight 25mg syringes per 28 days
❑ **Psoriatic Arthritis (PsA)**	• **Enbrel:** Four 50mg syringes, per 28 days • **Humira:** Two syringes/pens per 28 days

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DIAGNOSIS	Recommended Dose
❑ **Psoriatic Arthritis (PsA)**	• **Enbrel:** Four 50mg syringes, per 28 days • **Humira:** Two syringes/pens per 28 days
❑ **Rheumatoid Arthritis (RA)**	• **Enbrel:** Four 50mg syringes, OR eight 25mg syringes per 28 days • **Humira:** Two syringes/pens per 28 days
❑ **Ulcerative Colitis (UC)**	• **Humira:** Six syringes/pens in the initial 28 days • **Humira:** Two syringes/pens per 28 days after induction period

❑ **Uveitis (UV)**	• **Humira:** Adults: (Four syringes in the initial 28 days), then Two syringes/ pens per 28 days after induction period.
	• **Humira**: 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.

❑ 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: _____	

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.*