SENTARA HEALTH PLANS

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 Adalimumab Products (Pharmacy)

Drug Requested: select one drug below

Self-Funded Commercial Groups		
Self-Funded Groups Include: Atlantic Orthopaedic, CBBT, City of Suffolk, City of Newport News, City of Virginia Beach, Hampton City Schools, HRSD, James City County, Lyon Shipyard Inc., Marine Hydraulics, Portsmouth Public Schools, Regent University, Seaward Marine Corporation, Sentara Health, St Mary's Home, Tidewater Physicians, VCU Health System, and Virginia Beach Schools		
❑ **Cyltezo®** (adalimumab-adbm)	❑ **Humira®** (adalimumab)	❑ **Yuflyma®** (adalimumab-aaty)
Fully Insured Commercial Groups		
❑ **adalimumab-adbm**	❑ **Simlandi®** (adalimumab-ryvk)	

NOTE: Humira NDC's starting with 83457 are non-formulary, NDC's starting with 00074 (MFG: Abbvie) are preferred

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **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:** _____

NOTE: The Health Plan considers the use of concomitant therapy with more than one biologic immunomodulator (e.g., Dupixent, Entyvio, Humira, Rinvoq, Stelara) prescribed for the same or different indications to be experimental and investigational. Safety and efficacy of these combinations has **NOT** been established and will **NOT** be permitted.

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- Will the member be discontinuing a previously prescribed biologic if approved for requested medication?
  ❑ Yes **OR** ❑ No
- If yes, please list the medication that will be discontinued and the medication that will be initiated upon approval along with the corresponding effective date.

  Medication to be discontinued: _____ **Effective date:** _____

  Medication to be initiated: _____ **Effective date:** _____

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. **Check the diagnosis below that applies.**

❑ **Diagnosis: Moderate-to-Severe Rheumatoid Arthritis**
Dosing: SubQ: 40 mg every other week

- ❑ Member has a diagnosis of moderate-to-severe **rheumatoid arthritis**
- ❑ Prescribed by or in consultation with a **Rheumatologist**
- ❑ Member has tried and failed at least **ONE** of the following **DMARD** therapies for at least **three (3) months**
  - ❑ hydroxychloroquine
  - ❑ leflunomide
  - ❑ methotrexate
  - ❑ sulfasalazine

❑ **Diagnosis: Moderate-to-Severe Active Polyarticular Juvenile Idiopathic Arthritis**
Dosing: SubQ: 40 mg every other week

- ❑ Member has a diagnosis of moderate-to-severe active polyarticular **juvenile idiopathic arthritis**
- ❑ Prescribed by or in consultation with a **Rheumatologist**
- ❑ Member is ≥ 2 years of age
- ❑ Member has tried and failed at least **ONE** of the following **DMARD** therapies for at least **three (3) months**
  - ❑ cyclosporine
  - ❑ hydroxychloroquine
  - ❑ leflunomide
  - ❑ methotrexate
  - ❑ non-steroidal anti-inflammatory drugs (NSAIDs)
  - ❑ oral corticosteroids
  - ❑ sulfasalazine
  - ❑ tacrolimus

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❑ Diagnosis: Active Psoriatic Arthritis

Dosing: SubQ: 40 mg every other week

- ❑ Member has a diagnosis of active **psoriatic arthritis**
- ❑ Prescribed by or in consultation with a **Rheumatologist**
- ❑ Member has tried and failed at least **ONE** of the following **DMARD** therapies for at least **three (3) months**
  - ❑ cyclosporine
  - ❑ leflunomide
  - ❑ methotrexate
  - ❑ sulfasalazine

❑ Diagnosis: Active Ankylosing Spondylitis

Dosing: SubQ: 40 mg every other week.

- ❑ Member has a diagnosis of active **ankylosing spondylitis**
- ❑ Prescribed by or in consultation with a **Rheumatologist**
- ❑ Member tried and failed, has a contraindication, or intolerance to **TWO** NSAIDs

❑ Diagnosis: Moderate-to-Severe Hidradenitis Suppurativa (HS)

Dosing: SubQ: Initial: 160 mg (given on day 1 or split and given over 2 consecutive days); then 80 mg 2 weeks later (day 15). **Maintenance:** 40 mg every week beginning day 29.

- ❑ Member is ≥ 12 years of age and has a diagnosis of moderate-to-severe **hidradenitis suppurativa**
- ❑ Prescribed by or in consultation with a **Dermatologist**
- ❑ Member tried and failed a 90-day course of oral antibiotics (e.g., tetracycline, minocycline, doxycycline or clindamycin, rifampin) for treatment of HS **(within last 9 months)**

  Name of Antibiotic & Date: _____

❑ Diagnosis: Moderate-to-Severe Chronic Plaque Psoriasis

Dosing: SubQ: Initial: 80 mg as a single dose. **Maintenance:** 40 mg every other week beginning 1 week after initial dose.

- ❑ Member has a diagnosis of moderate-to-severe chronic **plaque psoriasis**
- ❑ Prescribed by or in consultation with a **Dermatologist**
- ❑ Member tried and failed at least **ONE** of either Phototherapy or Alternative Systemic Therapy for at least **three (3) months** (check each tried below):

❑ **Phototherapy:**	❑ **Alternative Systemic Therapy:**
❑ **UV Light Therapy** ❑ NB UV-B ❑ PUVA	❑ **Oral Medications** ❑ acitretin ❑ methotrexate ❑ cyclosporine

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❑ **Diagnosis: Moderate-to-Severe Active Crohn's Disease (CD)**
Dosing: SubQ: Initial: 160 mg (given on day 1 or split and given over 2 consecutive days); then 80 mg 2 weeks later (day 15). **Maintenance:** 40 mg every other week beginning day 29.

- ❑ Member is ≥ 6 years of age and has a diagnosis of moderate-to-severe active **Crohn's disease**
- ❑ Prescribed by or in consultation with a **Gastroenterologist**
- ❑ Member meets **ONE** of the following:
  - ❑ Member has tried and failed budesonide or high dose steroids (40-60 mg prednisone)
  - ❑ Member has tried and failed at least **ONE** of the following **DMARD** therapies for at least **three (3) months**
    - ❑ 5-aminosalicylates (balsalazide, olsalazine, sulfasalazine)
    - ❑ oral mesalamine (Apriso, Asacol/HD, Delzicol, Lialda, Pentasa)

❑ **Diagnosis: Moderate-to-Severe Ulcerative Colitis (UC)**
Dosing: SubQ: Initial: 160 mg (given on day 1 OR split and given over 2 consecutive days); then 80 mg 2 weeks later (day 15). **Maintenance:** 40 mg every other week beginning day 29.

- ❑ Member is ≥ 5 years of age and has a diagnosis of moderate-to-severe **ulcerative colitis**
- ❑ Prescribed by or in consultation with a **Gastroenterologist**
- ❑ Member meets **ONE** of the following:
  - ❑ Member has tried and failed budesonide or high dose steroids (40-60 mg prednisone)
  - ❑ Member has tried and failed at least **ONE** of the following **DMARD** therapies for at least **three (3) months**
    - ❑ 5-aminosalicylates (balsalazide, olsalazine, sulfasalazine)
    - ❑ oral mesalamine (Apriso, Asacol/HD, Delzicol, Lialda, Pentasa)

❑ **Diagnosis: Uveitis (non-infectious intermediate, posterior, and panuveitis)**
Dosing: SubQ: Initial: 80 mg as a single dose. Maintenance: 40 mg every other week beginning 1 week after initial dose.

- ❑ Member is ≥ 2 years of age and has a diagnosis of Uveitis **(check box below for diagnosis that applies)**:

❑ Chronic	❑ Treatment-refractory
❑ Recurrent	❑ Vision-threatening disease

- ❑ Prescribed by or in consultation with an **Ophthalmologist or Rheumatologist**

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- ❑ Member must have trial and failure of **ONE** of the following therapies:
  - ❑ azathioprine
  - ❑ cyclosporine
  - ❑ methotrexate
  - ❑ oral corticosteroids at a prednisone dose equivalent of at least 60 mg/day

Medication being provided by a Specialty Pharmacy – Proprium Rx

Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

****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.****