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

Drug Requested: select one drug below

❑ **adalimumab-adbm** (MFG: Boehringer Ingelheim)	❑ **Simlandi®** (adalimumab-ryvk)

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:** _____

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.

❑ 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:** _____

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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 meets **ONE** of the following:
  - ❑ Member has tried and failed at least **ONE** of the following **DMARD** therapies for at least three **(3) months**:
    - ❑ hydroxychloroquine
    - ❑ leflunomide
    - ❑ methotrexate
    - ❑ sulfasalazine
  - ❑ Member has previously tried and failed another biologic medication other than the requested medication (e.g., Enbrel, tofacitinib, Rinvoq)

❑ 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 meets **ONE** of the following:
  - ❑ Member has tried and failed at least **ONE** of the following **DMARD** therapies for at least **three (3) months**:
    - ❑ cyclosporine
    - ❑ hydroxychloroquine
    - ❑ leflunomide
    - ❑ methotrexate
    - ❑ sulfasalazine
  - ❑ Member has previously tried and failed another biologic medication other than the requested medication (e.g., Enbrel, tofacitinib, Rinvoq)

❑ 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 **ONE** NSAID

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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 or Dermatologist**
- ❑ Member meets **ONE** of the following:
  - ❑ Member has tried and failed at least **ONE** of the following **DMARD** therapies for at least **three (3) months**:
    - ❑ cyclosporine
    - ❑ leflunomide
    - ❑ methotrexate
    - ❑ sulfasalazine
  - ❑ Member has previously tried and failed another biologic medication other than the requested medication (e.g., Enbrel, Otezla, Skyrizi)

❑ 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 meets **ONE** of the following:
  - ❑ Member tried and failed at least **ONE** of either Phototherapy or Alternative Systemic Therapy for at least **three (3) months**, unless member has a contraindication or intolerance to both phototherapy and alternative systemic therapies **(check each tried below)**:

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

  - ❑ Member has tried and failed another biologic medication other than the requested medication (e.g., Enbrel, Otezla, ustekinumab)

❑ 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: _____

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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 unless member has a contraindication or intolerance:
  - ❑ Member has tried and failed corticosteroids
  - ❑ Member has tried and failed at least one conventional systemic therapy (e.g., azathioprine, 6-mercaptopurine, or methotrexate)
  - ❑ Member has previously tried and failed another biologic medication other than the requested medication (e.g., Skyrizi, Tremfya, ustekinumab)

❑ **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 unless member has a contraindication or intolerance:
  - ❑ Member has tried and failed corticosteroids
  - ❑ Member has tried and failed at least **ONE** of the following **DMARD**:
    - ❑ 5-aminosalicylates (balsalazide, olsalazine, sulfasalazine)
    - ❑ oral mesalamine (Apriso, Asacol/HD, Delzicol, Lialda, Pentasa)
    - ❑ Other immunosuppressant drug: _____
  - ❑ Member has previously tried and failed another biologic medication other than the requested medication (e.g., Skyrizi, Tremfya, ustekinumab)

❑ **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

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.*

***Approved by Pharmacy and Therapeutics Committee:** ~~11/21/2024; 5/22/2025;~~ ~~3/26/2026; 5/28/2026;~~ **9/24/2026**
REVISED/UPDATED/REFORMATTED: ~~6/8/2017; 8/8/2017; 9/8/2017; 12/11/2017; 4/10/2018; 11/23/2018; 9/28/2019; 11/20/2019; 12/23/2021; 2/24/2022; 12/20/2022; 5/26/2023; 8/13/2023; 10/26/2023; 2/9/2024; 3/27/2024; 4/29/2024 12/16/2024, 6/18/2025; 7/8/2025, 12/22/2025, 6/15/2026;~~
8/6/2026