



Would you like to use electronic prior authorization? Consider using Surescripts, our electronic prior authorization portal at providerportal.surescripts.net/ProviderPortal/login OR fax completed prior authorization request form to 800-750-9692.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at sentarahealthplans.com/en/providers/authorizations/prescription-drugs

Adalimumab (Medicare)

REQUIRED: Office notes, labs, and medical testing relevant to request showing medical justification to support diagnosis					
Member Information					
Member Name (first & last):		Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Height:	
Member ID:	City:		State: Weight:		
Prescribing Provider Information					
Requestor's Name:		Requestor's Phone Number:		Requestor's Fax Number:	
Provider Name (first & last):	Specialty	NPI:	DEA:		
Office Address:		City:		State: Zip Code:	
Office Contact:			Office Phone:	Office Fax:	
Dispensing Provider/Pharmacy Information					
Place of Administration:	<input type="checkbox"/> Self-Administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Home <input type="checkbox"/> Home Infusion Center <input type="checkbox"/> Outpatient Infusion Center Name: _____				
Agency NPI:	Agency Name:		Agency Phone Number:		
Agency Address			Agency Fax Number:		
City:		State:	Zip:		
Dispensing Location:	<input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Mail Order <input type="checkbox"/> Physician's Office <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Other				
Pharmacy Name:		Pharmacy Phone:		Pharmacy Fax:	
Pharmacy NPI:					
Requested Medication Information					
Medication request is NOT for an FDA approved, or compendia-supported diagnosis (check one): <input type="checkbox"/> Yes <input type="checkbox"/> No			Diagnosis:	ICD-10 Code:	
Are there any contraindications to formulary medications? If yes, please specify:			Is this a New Request or Continuation of Therapy: <input type="checkbox"/> New, start date: ____/____/_____ <input type="checkbox"/> Continuation, date of last treatment: ____/____/_____		
Directions for Use:			Strength:	Dosage Form	
			Duration:	Quantity:	Days Supply:
What medication(s) has the member tried and failed for this diagnosis? Please specify below including duration of treatment.					
Turn-Around Time for Review:					
<input type="checkbox"/> Standard <input type="checkbox"/> Urgent: Waiting standard time for decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision.					
Signature: _____					



Sentara®

Health Plans Member First Name: _____ Member Last Name: _____

Member ID: _____ Member Date of Birth: _____

Clinical Information:

* Indicate questions that are required to be answered

Q1. For Reauthorization: Has the member responded positively to therapy as determined by the prescribing physician?

Yes

No

Q2. Please select applicable diagnosis: *

<input type="checkbox"/> Ankylosing Spondylitis (AS)	<input type="checkbox"/> Polyarticular Juvenile Idiopathic Arthritis (PJIA)
<input type="checkbox"/> Crohn's Disease (CD)	<input type="checkbox"/> Psoriatic Arthritis (PsA)
<input type="checkbox"/> Hidradentis Suppurativa (HS)	<input type="checkbox"/> Rheumatoid Arthritis (RA)
<input type="checkbox"/> Juvenile Psoriatic Arthritis (JPsA)	<input type="checkbox"/> Ulcerative Colitis (UC)
<input type="checkbox"/> Juvenile Rheumatoid Arthritis (JRA)	<input type="checkbox"/> Uveitis
<input type="checkbox"/> Plaque Psoriasis (PsO)	

Q3. For all diagnoses: Will the medication be used concomitantly with other biologics, targeted synthetic DMARDs, potent immunosuppressants, anti-interleukin monoclonal antibodies, or janus kinase (JAK) inhibitors?

Yes

No

Q4. For all diagnoses: Has the medication been prescribed by or in consultation with one of the following:

- RA/AS/JIA/JRA: Rheumatologist
- PsA: Rheumatologist or dermatologist
- PsO and HS: Dermatologist
- UC/CD: Gastroenterologist.
- UV: Ophthalmologist
- None of the above

Q5. For all diagnoses: Is the member's disease moderately to severely active?

Yes

No

Q6. For all diagnoses: Will latent tuberculosis (TB) test prior to starting treatment and monitoring for active TB throughout treatment even if initial latent TB test is negative?

Yes

No

Q7. For CD: Does the member have evidence of large or deep ulcers, strictures, or extensive areas of disease and/or evidence of stricturing, penetrating, or perianal disease on endoscopy?

Yes

No

Q8. For AS: Does the member have signs and symptoms of active disease (i.e. back pain and stiffness in the lower back and hips, neck pain and fatigue, skin rashes)?



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Member ID: _____ Member Date of Birth: _____

Yes

No

Q9. For PsA/JPsA: Has documentation been sent showing the presence of at least one of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, active skin or nail involvement, or extraarticular manifestations such as uveitis or inflammatory bowel disease (IBD)?

Yes

No

Q10. For UC: Which of the following does the member have:

- Member presents with frequent, bloody stools that occur 6 or more times daily or frequent and heavy rectal bleeding
- Member has severe inflammation or ulcers as visualized on endoscopy
- None of the above