

OPTIMA HEALTH PLAN

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. Incomplete form will delay authorization process.*

Drug Requested: **Humira®** (adalimumab) (*Preferred*)

DRUG INFORMATION: Complete information below. If incomplete, authorization process will be delayed.

Drug Form/Strength/Quantity: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code, if applicable:** _____

CLINICAL CRITERIA: Complete **ALL** applicable boxes below to qualify. Documented chart notes **MUST** be submitted and attached to this request form or authorization process will be delayed.

• **Prescriber is (check applicable box below)**

- Rheumatologist Gastroenterologist Dermatologist

DIAGNOSIS: Applicable diagnosis below **MUST** be checked to qualify. All chart notes **MUST** be attached to this request or authorization process will be delayed.

Part A - DMARD therapy

Trial and failure of **at least one DMARD** therapy for **at least three (3) months** (check each tried):

<input type="checkbox"/> 6-mercaptopurine	<input type="checkbox"/> methotrexate	<input type="checkbox"/> azathioprine
<input type="checkbox"/> hydroxychloroquine	<input type="checkbox"/> auranofin	<input type="checkbox"/> sulfasalazine
<input type="checkbox"/> leflunomide	<input type="checkbox"/> aminosalicylates	<input type="checkbox"/> Other: _____
<input type="checkbox"/> olsalazine (Crohn's/Ulcerative Colitis)	<input type="checkbox"/> mesalamine (Crohn's/Ulcerative Colitis)	

<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Juvenile Arthritis	<input type="checkbox"/> Ankylosing Spondylitis	<input type="checkbox"/> Psoriatic Arthritis
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Trial and failure of **at least one DMARD** therapy for **at least three (3) months** (check each tried) (*Refer to Part A*).

• For **MODERATE-SEVERE Hidradenitis suppurative** (HS) - **all** boxes below **must** be checked to qualify. All chart notes and lab values **MUST** be included with this request.

- Has patient been diagnosed with HS for at least 1 year? Yes No
- Are HS lesions in at least two (2) distinct areas of the body? Yes No
- One area of the body
- AND**
- Hurley Stage II (*defined as one or more widely separated recurrent abscesses with tract formation and scars*)
- OR**
- Hurley Stage III (*defined as multiple interconnected tracts and abscesses throughout an entire area*)
- AND**
- Failed a 90-day treatment of oral antibiotics for HS (*within last 9 months*) Yes No
- Name of Antibiotic & Date:** _____

• For **Plaque Psoriasis/one (1) fingernail with nail psoriasis:**

- Does the patient's Psoriasis involve: palms, soles, face, genitalia, or greater than 10% of total body surface area? Yes No

(continued on next page)

- Patient tried and failed at least one of either Phototherapy or Alternative Systemic Therapy for at least three (3) months (check each tried):

<u>Phototherapy</u>		<u>OR</u>	<u>Alternative Systemic Therapy</u>		
<input type="checkbox"/> UV Light Therapy			<input type="checkbox"/> Oral Alternative Systemic Therapy		
<input type="checkbox"/> NB UV-B	<input type="checkbox"/> PUVA		<input type="checkbox"/> acitretin	<input type="checkbox"/> methotrexate	<input type="checkbox"/> cyclosporine

- For Crohn's indication, disease is moderate to severe with inadequate response to:

budesonide or high dose steroids (40-60 mg prednisone) **AND** DMARD therapy (Refer to Part A)

- For Ulcerative Colitis indication, disease is moderately to severely active with inadequate response to:

aminosalicylate (Refer to Part A) **AND** budesonide or high dose steroids (40-60 mg prednisone)

- Non-infectious Uveitis:

<input type="checkbox"/> Chronic	<input type="checkbox"/> Treatment-refractory
<input type="checkbox"/> Recurrent	<input type="checkbox"/> Vision-threatening disease

- Patient has tried and failed one of the DMARD therapies for at least three (3) months: (Refer to Part A)

<input type="checkbox"/> methotrexate	<input type="checkbox"/> azathioprine	<input type="checkbox"/> cyclosporine
<input type="checkbox"/> acitretin	<input type="checkbox"/> leflunomide	

OR

Patient tried and failed corticosteroid therapy: Prednisone 60mg/day

Medication being provided by (check applicable box below):

Physician's office

OR

Specialty Pharmacy:

For Optima Commercial Members:

PropriumRx

For Optima Family Care Members:

Sentara Norfolk General CM Pharmacy

****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.

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

*REVISED/UPDATED: 7/16/09; 6/3/2011; 8/18/2011; 6/28/12; 1/17/13; 5/20/2013; 1/16/2014; 1/27/2014; 2/19/2014; 4/4/2014; 4/28/2014; 8/13/2014; 10/31/2014; 5/21/2015; 10/15/15; 10/29/2015; 12/22/2015; 9/22/2016; 8/16/2016; 11/14/2016; 12/21/2016; 6/8/2017; 8/8/2017; 9/8/2017; 12/11/2017; 4/10/2018