

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)

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:** _____

CHART NOTES MUST BE SUBMITTED FOR DOCUMENTATION AND ATTACHED

CLINICAL CRITERIA: Complete **ALL** applicable boxes below. To qualify, all boxes **must** be checked to qualify or authorization process will be delayed.

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

- Rheumatologist Gastroenterologist Dermatologist

• **Patient has a diagnosis of one of the following diagnoses (indicate which diagnosis):**

<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Juvenile Arthritis	<input type="checkbox"/> Ankylosing Spondylitis	<input type="checkbox"/> Plaque Psoriasis
<input type="checkbox"/> Psoriatic Arthritis	<input type="checkbox"/> Crohn's Disease	<input type="checkbox"/> Ulcerative Colitis	<input type="checkbox"/> MODERATE-SEVERE Hidradenitis suppurative

• **For MODERATE-SEVERE Hidradenitis suppurative (HS) (complete below; all boxes **must** be checked to qualify):**

- 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*)

- Failed a 90-day treatment of oral antibiotics for HS Yes No

Name of Antibiotic & Date: _____

• Patient has tried and failed **at least one DMARD** therapy for **at least three (3) months** for **ALL** diagnosis **except Plaque Psoriasis and HS**:

<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

• For **Plaque Psoriasis AND at least 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

Trial and failure of:

Phototherapy

OR

Alternative Systemic Therapy:

<input type="checkbox"/> UV Light Therapy <input type="checkbox"/> NB UV-B <input type="checkbox"/> PUVA	<input type="checkbox"/> Oral Alternative Systemic Therapy <input type="checkbox"/> acitretin <input type="checkbox"/> methotrexate <input type="checkbox"/> cyclosporine
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- For Crohn's indication, disease is moderate to severe with inadequate response to:
 - budesonide or high dose (40-60 mg prednisone) steroids **AND** DMARD therapy
- For Ulcerative Colitis indication, disease is moderately to severely active with inadequate response to:
 - aminosalicylate **AND** 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 following therapies for at least three (3) months:

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

OR

- Patient has 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**