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)***:

❑ 6-mercaptopurine	❑ methotrexate	❑ azathioprine
❑ hydroxychloroquine	❑ auranofin	❑ sulfasalazine
❑ leflunomide	❑ aminosalicylates	❑ Other: _____
❑ olsalazine (Crohn's/Ulcerative Colitis)	❑ mesalamine (Crohn's/Ulcerative Colitis)	

❑ **Rheumatoid Arthritis**	❑ **Juvenile Arthritis**	❑ **Ankylosing Spondylitis**	❑ **Psoriatic Arthritis**

❑ 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)

- Does the patient's Psoriasis involve: palms, soles, face, genitalia, or greater than 10% of total body surface area?
  ❑ Yes ❑ No
- Patient tried and failed at least ***one of either*** Phototherapy or Alternative Systemic Therapy for ***at least three (3) months*** ***(check each tried)***:

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

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

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

❑ methotrexate	❑ azathioprine	❑ cyclosporine
❑ acitretin	❑ 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**