AvMed

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 1-305-671-0200**. 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 (Pharmacy)

Drug Requested: (Select drug requested below)

❑ **Cyltezo®** (adalimumab-adbm)	❑ **Humira®** (adalimumab)	❑ **Hyrimoz®** (adalimumab-adaz)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

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

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

Weight: _____ **Date:** _____

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.

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.**

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❑ 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 has tried and failed at least **ONE** of the following **DMARD** therapies for at least **three (3) months**
  - ❑ hydroxychloroquine
  - ❑ leflunomide
  - ❑ methotrexate
  - ❑ sulfasalazine

❑ 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 has tried and failed at least **ONE** of the following **DMARD** therapies for at least **three (3) months**
  - ❑ cyclosporine
  - ❑ hydroxychloroquine
  - ❑ leflunomide
  - ❑ methotrexate
  - ❑ non-steroidal anti-inflammatory drugs (NSAIDs)
  - ❑ oral corticosteroids
  - ❑ sulfasalazine
  - ❑ tacrolimus

❑ 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**
- ❑ Member has tried and failed at least **ONE** of the following **DMARD** therapies for at least **three (3) months**
  - ❑ cyclosporine
  - ❑ leflunomide
  - ❑ methotrexate
  - ❑ sulfasalazine

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❑ **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 **TWO** NSAIDs

❑ **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**
- ❑ Member has been diagnosed with HS for at least 1 year
- ❑ Prescribed by or in consultation with a **Dermatologist**
- ❑ HS lesions are present on at least two (2) distinct areas of the body and **ONE** of the following must be met:
  - ❑ Extent of disease is Hurley Stage II **(defined as one or more widely separated recurrent abscesses with tract formation and scars)** for HS lesions located on at least one area of the body
  - ❑ Extent of disease is Hurley Stage III **(defined as multiple interconnected tracts and abscesses throughout an entire area)** for HS lesions located on at least one area of the body
- ❑ 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: _____
- ❑ For current smokers (if applicable), provider must submit documentation indicating smoking cessation has been addressed
- ❑ Provider must submit documentation indicating member has been counseled on the importance of weight management
- ❑ Provider must submit documentation indicating member has been counseled on the use of general supportive measures (e.g., education and support, avoidance of skin trauma, hygiene, dressings, diet)

❑ **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**

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- ❑ Member tried and failed at least **ONE** of either Phototherapy or Alternative Systemic Therapy for at least **three (3) months** (check each tried below):

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

❑ **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:
  - ❑ Member has tried and failed budesonide or high dose steroids (40-60 mg prednisone)
  - ❑ Member has tried and failed at least **ONE** of the following **DMARD** therapies for at least **three (3) months**
    - ❑ 5-aminosalicylates (balsalazide, olsalazine, sulfasalazine)
    - ❑ oral mesalamine (Apriso, Asacol/HD, Delzicol, Lialda, Pentasa)

❑ **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:
  - ❑ Member has tried and failed budesonide or high dose steroids (40-60 mg prednisone)
  - ❑ Member has tried and failed at least **ONE** of the following **DMARD** therapies for at least **three (3) months**
    - ❑ 5-aminosalicylates (balsalazide, olsalazine, sulfasalazine)
    - ❑ oral mesalamine (Apriso, Asacol/HD, Delzicol, Lialda, Pentasa)

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❑ **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**
- ❑ 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.*