maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Adalimumab Products

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Will the requested medication be used in combination with a biologic disease-modifying antirheumatic drug (DMARD) or targeted synthetic DMARD? [Note: Examples of biologics include but not limited to Actemra (IV or SC), Cimzia, Cosentyx, an etanercept SC product (for example, Enbrel, biosimilars), Ilumya, Skyrizi, Kevzara, Kineret, Orencia (IV or SC), an infliximab IV product (for example, Remicade, biosimilars), a rituximab IV product (for example, Rituxan, biosimilars), Siliq, Stelara (IV or SC), Taltz, Tremfya, Entyvio, or Simponi (Aria or SC). Examples of targeted synthetic DMARD include but not limited to Olumiant, Otezla, Rinvoq or Xeljanz/XR.]	Yes	No

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	[If yes, no further questions.]		
2	Is the patient currently receiving an adalimumab product? [If no, skip to question 9.]	Yes	No
3	Has the patient been receiving medication samples for an adalimumab product? [If yes, skip to question 9.]	Yes	No
4	Does the patient have a previously approved PA on file with the current plan for an adalimumab product? [If no, skip to question 6.]	Yes	No
5	Has the patient been established on therapy for at least 3 months? [If yes, skip to question 7.] [If no, skip to question 9.]	Yes	No
6	Has documentation been submitted to confirm that the patient has had a clinically significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 9.] [If no, no further questions.]	Yes	No
7	What is the indication or diagnosis? [] Rheumatoid Arthritis (If checked, go to 8) [] Ankylosing Spondylitis (If checked, go to 8) [] Crohn's Disease (If checked, go to 8) [] Juvenile Idiopathic Arthritis or Juvenile Rheumatoid Arthritis (regardless of type of onset) [Note: This includes patients with juvenile spondyloarthropathy/active sacroiliac arthritis.] (If checked, go to 8) [] Hidradenitis Suppurativa (If checked, go to 8) [] Plaque Psoriasis (If checked, go to 8) [] Psoriatic Arthritis (If checked, go to 8) [] Ulcerative Colitis (If checked, go to 8) [] Uveitis (including other posterior uveitis and panuveitis syndromes) (If checked, go to 8) [] Behcet's Disease (If checked, go to 8) [] Pyoderma Gangrenosum (If checked, go to 8)		

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	[] Sarcoidosis (If checked, go to 8) [] Scleritis or Sterile Corneal Ulceration (If checked, go to 8) [] Spondyloarthritis, other subtypes (for example, undifferentiated arthritis, non-radiographic axial sponyloarthritis, Reactive Arthritis [Reiter's disease], arthritis associated with inflammatory bowel disease [IBD]) (If checked, go to 8) [] Enthesitis-Related Arthritis (If checked, go to 8) [] Polymyalgia Rheumatica (PMR) (If checked, no further questions) [] Other (If checked, no further questions)		
8	Has documentation been submitted to confirm that the patient has had a clinically significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
9	Is the request for a formulary Adalimumab product? [If yes, skip to question 11.]	Yes	No
10	Does the patient have documented intolerance, contraindication to, or failed treatment for at least 3 months with preferred Adalimumab product(s)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions]	Yes	No
11	What is the indication or diagnosis? [] Rheumatoid Arthritis (If checked, go to 12) [] Ankylosing Spondylitis (If checked, go to 15) [] Crohn's Disease (If checked, go to 17) [] Juvenile Idiopathic Arthritis or Juvenile Rheumatoid Arthritis (regardless of type of onset) [Note: This includes patients with juvenile spondyloarthropathy/active sacroiliac arthritis.] (If checked, go to 25) [] Hidradenitis Suppurativa (If checked, go to 31) [] Plaque Psoriasis (If checked, go to 34) [] Psoriatic Arthritis (If checked, go to 38) [] Ulcerative Colitis (If checked, go to 41) [] Uveitis (including other posterior uveitis and panuveitis syndromes) (If checked, go to 47)		

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[] Behcet's Disease (If checked, go to 50)

[] Pyoderma Gangrenosum (If checked, go to 53)

[] Sarcoidosis (If checked, go to 56)

[] Scleritis or Sterile Corneal Ulceration (If checked, go to 59)

[] Spondyloarthritis, other subtypes (for example, undifferentiated arthritis, non-radiographic axial sponyloarthritis, Reactive Arthritis [Reiter's disease], arthritis associated with inflammatory bowel disease [IBD]) (If checked, go to 61)

[] Enthesitis-Related Arthritis (If checked, go to 67)

[] Polymyalgia Rheumatica (PMR) (If checked, no further questions)

[] Other (If checked, no further questions)

12	Has the patient tried ONE conventional synthetic disease-modifying antirheumatic drug (DMARD) for at least 3 months or was intolerant to a conventional synthetic DMARD? [Note: Examples of conventional synthetic DMARDs include but not limited to methotrexate (oral or injectable), leflunomide, hydroxychloroquine, and sulfasalazine.] [If no, no further questions.]	Yes	No
13	Does the requested dose exceed FDA approved label dosing for the requested indication? (Dosing: 40 mg every other week.) [If yes, no further questions.]	Yes	No
14	Is the requested medication prescribed by or in consultation with a rheumatologist? [No further questions.]	Yes	No
15	Does the requested dose exceed FDA approved label dosing for the requested indication? (Dosing: 40 mg every other week.) [If yes, no further questions.]	Yes	No
16	Is the requested medication prescribed by or in consultation with a rheumatologist? [No further questions.]	Yes	No
17	Is the patient greater than or equal to 6 years of age? [If no, no further questions.]	Yes	No

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18	Has the patient tried or is currently taking corticosteroids? [Note: Examples of corticosteroids include but not limited to prednisone, methylprednisolone.] [If yes, skip to question 20.]	Yes	No
19	Are corticosteroids contraindicated in this patient? [Note: Examples of corticosteroids include but not limited to prednisone, methylprednisolone.] [If no, no further questions.]	Yes	No
20	Has the patient tried ONE other agent for Crohn's disease for at least 3 months? [Note: Examples of other agents for Crohn's disease include but not limited to azathioprine, 6-mercaptopurine, or methotrexate (MTX).] [If yes, skip to question 23.]	Yes	No
21	Does the patient have enterocutaneous (perianal or abdominal) or rectovaginal fistulas? [If yes, skip to question 23.]	Yes	No
22	Has the patient had ileocolonic resection (to reduce the chance of Crohn's disease recurrence)? [If no, no further questions.]	Yes	No
23	Does the requested dose exceed FDA approved label dosing for the requested indication? (Dosing: 160 mg at week 0, 80 mg at week 2, and then 40 mg every other week at week 4 thereafter.) [If yes, no further questions.]	Yes	No
24	Is the requested medication prescribed by or in consultation with a gastroenterologist? [No further questions.]	Yes	No
25	Has the patient tried ONE other agent for at least 3 months for the patient's condition? [Note: Examples of other agents for JIA include but not limited to methotrexate (MTX), sulfasalazine, or leflunomide, a nonsteroidal anti-inflammatory drug (NSAID) [for example, ibuprofen, naproxen].] [If yes, skip to question 29.]	Yes	No
26	Will the patient be starting on the requested medication concurrently with methotrexate (MTX), sulfasalazine, or leflunomide? [If yes, skip to question 29.]	Yes	No
27	Does the patient have an absolute contraindication to methotrexate (MTX), sulfasalazine, or leflunomide? [Note: Examples of contraindications to MTX include pregnancy, breast feeding, alcoholic liver disease, immunodeficiency syndrome, blood dyscrasias.]	Yes	No

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	[If yes, skip to question 29.]		
28	Does the patient have aggressive disease, as determined by the prescriber? [If no, no further questions.]	Yes	No
29	Does the requested dose exceed FDA approved label dosing for the requested indication? (Dosing: 40 mg every other week.) [If yes, no further questions.]	Yes	No
30	Is the requested medication prescribed by or in consultation with a rheumatologist? [No further questions.]	Yes	No
31	Has the patient tried at least ONE other therapy for at least 3 months? [Note: Examples include but not limited to intralesional or oral corticosteroids (such as triamcinolone, prednisone), systemic antibiotics (for example, clindamycin, dicloxacillin, erythromycin), or isotretinoin.] [If no, no further questions.]	Yes	No
32	Does the requested dose exceed FDA approved label dosing for the requested indication? (Dosing: 160 mg at week 0, 80 mg at week 2, and then 40 mg every week at week 4 thereafter.) [If yes, no further questions.]	Yes	No
33	Is the requested medication prescribed by or in consultation with a dermatologist? [No further questions.]	Yes	No
34	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
35	Has the patient tried at least TWO traditional systemic agents for psoriasis for at least 3 months or was intolerant to traditional systemic agents? [Note: Examples include but not limited to methotrexate (MTX), cyclosporine, acitretin (Soriatane generics).] [If no, no further questions.]	Yes	No
36	Does the requested dose exceed FDA approved label dosing for the requested indication? (Dosing: 80 mg at week 0, and then 40 mg every other week starting at week 1 thereafter.) [If yes, no further questions.]	Yes	No
37	Is the requested medication prescribed by or in consultation with a dermatologist? [No further questions.]	Yes	No
38	Has the patient tried ONE conventional synthetic disease-modifying antirheumatic	Yes	No

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	drug (DMARD) for at least 3 months or was intolerant to conventional synthetic DMARD? [Note: Examples of conventional synthetic DMARDs include but not limited to methotrexate (oral or injectable), leflunomide, hydroxychloroquine and sulfasalazine.] [If no, no further questions.]		
39	Does the requested dose exceed FDA approved label dosing for the requested indication? (Dosing: 40 mg every other week.) [If yes, no further questions.]	Yes	No
40	Is the requested medication prescribed by or in consultation with a rheumatologist or a dermatologist? [No further questions.]	Yes	No
41	Is the patient greater than or equal to 5 years of age? [If no, no further questions.]	Yes	No
42	Has the patient had a trial of ONE systemic agent for at least 3 months or was intolerant to systemic agents? [Note: Examples include but not limited to 6-mercaptopurine, azathioprine, cyclosporine, tacrolimus, or a corticosteroid such as prednisone or methylprednisolone.] [If yes, skip to question 45.]	Yes	No
43	Does the patient have pouchitis? [If no, no further questions.]	Yes	No
44	Has the patient tried therapy with an antibiotic, probiotic, corticosteroid enema, or Rowasa (mesalamine) enema? [Note: Examples of antibiotics include but not limited to metronidazole and ciprofloxacin. Examples of corticosteroid enemas include but not limited to hydrocortisone enema (Cortenema, generics).] [If no, no further questions.]	Yes	No
45	Does the requested dose exceed FDA approved label dosing for the requested indication? (Dosing: 160 mg at week 0, 80 mg at week 2, and then 40 mg every other week at week 4 thereafter.) [If yes, no further questions.]	Yes	No
46	Is the requested medication prescribed by or in consultation with a gastroenterologist? [No further questions.]	Yes	No
47	Has the patient tried ONE of the following therapies: A) Periocular corticosteroids, B) Intraocular corticosteroids, C) Systemic corticosteroids for at least 3 months for	Yes	No

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	the patient's condition or was intolerant to the therapy? [Note: Examples of corticosteroids include but not limited to prednisolone, triamcinolone, betamethasone, methylprednisolone, and prednisone.] [If no, no further questions.]		
48	Does the requested dose exceed FDA approved label dosing for the requested indication? (Dosing: 80 mg at week 0, and then 40 mg every other week starting at week 1 thereafter.) [If yes, no further questions.]	Yes	No
49	Is the requested medication prescribed by or in consultation with an ophthalmologist? [No further questions.]	Yes	No
50	Has the patient tried at least ONE conventional therapy for at least 3 months? [Note: Examples include but not limited to systemic corticosteroids (for example, methylprednisolone), immunosuppressants [for example, azathioprine, methotrexate (MTX), mycophenolate mofetil, cyclosporine, tacrolimus, Leukeran (chlorambucil), cyclophosphamide], interferon alfa.] [If yes, skip to question 52.]	Yes	No
51	Does the patient have ophthalmic manifestations of Behcet's disease? [If no, no further questions.]	Yes	No
52	Is the requested medication prescribed by or in consultation with a rheumatologist, dermatologist, ophthalmologist, gastroenterologist, or neurologist? [No further questions.]	Yes	No
53	Has the patient tried ONE systemic corticosteroid for at least 3 months? [Note: An example is prednisone.] [If yes, skip to question 55.]	Yes	No
54	Has the patient tried ONE other immunosuppressant for at least 2 months or was intolerant to one of these agents? [Note: Examples include but not limited to mycophenolate mofetil and cyclosporine.] [If no, no further questions.]	Yes	No
55	Is the requested medication prescribed by or in consultation with a dermatologist? [No further questions.]	Yes	No
56	Has the patient tried at least ONE corticosteroid for at least 3 months for this condition? [Note: An example is prednisone.] [If no, no further questions.]	Yes	No
57	Has the patient tried at least ONE immunosuppressive agent for at least 3	Yes	No

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	months? [Note: Examples include but not limited to methotrexate (MTX), leflunomide, azathioprine, mycophenolate mofetil, cyclosporine, Leukeran (chlorambucil), cyclophosphamide, Thalomid (thalidomide capsules), an infliximab product, or chloroquine.] [If no, no further questions.]		
58	Is the requested medication prescribed by or in consultation with a pulmonologist, ophthalmologist, or dermatologist? [No further questions.]	Yes	No
59	Has the patient tried ONE other therapy for at least 3 months for the patient's condition? [Note: Examples include but not limited to oral nonsteroidal anti-inflammatory drugs (NSAIDs) such as indomethacin, naproxen, or ibuprofen; oral, topical (ophthalmic) or IV corticosteroids (such as prednisone, prednisolone, methylprednisolone); methotrexate (MTX); cyclosporine; or other immunosuppressants.] [If no, no further questions.]	Yes	No
60	Is the requested medication prescribed by or in consultation with an ophthalmologist? [No further questions.]	Yes	No
61	Does the patient have arthritis primarily in the knees, ankles, elbows, wrists, hands, and/or feet? [If no, skip to question 63.]	Yes	No
62	Has the patient tried at least ONE conventional synthetic disease-modifying antirheumatic drug (DMARD) for at least 3 months? [Note: Examples include but not limited to methotrexate (MTX), leflunomide, sulfasalazine.] [If yes, skip to question 66.]	Yes	No
63	Does the patient have axial spondyloarthritis? [If no, no further questions.]	Yes	No
64	Does the patient have objective signs of inflammation, defined as: C-reactive protein (CRP) elevated beyond the upper limit of normal for the reporting laboratory? [If yes, skip to question 66.]	Yes	No
65	Does the patient have objective signs of inflammation, defined as: sacroiliitis reported on magnetic resonance imaging (MRI)? [If no, no further questions.]	Yes	No
66	Is the requested medication prescribed by or in consultation with a rheumatologist?	Yes	No

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	[No further questions.]		
67	Is the patient greater than or equal to 2 years of age? [If no, no further questions.]	Yes	No
68	Has the patient tried at least ONE systemic agent for at least 3 months? [Note: Examples of systemic agents include but not limited to NSAIDs such as ibuprofen and naproxen.] [If yes, skip to question 70.]	Yes	No
69	Has documentation been submitted to confirm that the patient has intolerance to at least TWO systemic agents? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
70	Does the requested dose exceed FDA approved label dosing for the requested indication? (Dosing: 40 mg every other week.) [If yes, no further questions.]	Yes	No
71	Is the requested medication prescribed by or in consultation with a rheumatologist?	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

If you have any questions, call: 1-888-258-8250

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