SENDERO HEALTH PLANS

Prior Authorization Request Form	HUMIRA
Sendero Fax: 512-901-9724	**Phone:** 855-297-9191
URGENCY: ☐ **STANDARD**	☐ **URGENT (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health or ability to regain maximum function)**

Provider Information	Patient Information
Referring/Prescribing Physician: ☐ **PCP** ☐ **Specialist** **Name:** **Please identify SPECIALTY:** **DEA, NPI or TIN:** **Contact:** **Phone: ( ) Fax: ( )**	**Patient's Name:** **Birth Date:** **ID Number:** **Phone Number:** **Patient Height:** **Patient Weight:**

Indicate where the drug is being DISPENSED	Indicate where the drug is being ADMINISTERED
☐ **Ambulatory Surgery Center**	☐ **Ambulatory Surgery Center**
☐ **Home Care Agency**	☐ **Inpatient Hospital**
☐ **Inpatient Hospital**	☐ **Long Term Care**
☐ **Long Term Care**	☐ **Outpatient Hospital**
☐ **Outpatient Hospital**	☐ **Patient's Home**
☐ **Patient's Home**	☐ **Pharmacy**
☐ **Pharmacy**	☐ **Physician's Office**
☐ **Physician's Office**	☐ **Other (explain):**
☐ **Other (explain):**	**Anticipated Date of Service:**

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

PATIENT CLINICAL INFORMATION

CRITERIA QUESTIONS:

1. Has the patient been diagnosed with any of the following?
   - ☐ Rheumatoid arthritis (RA)
   - ☐ Psoriasis
   - ☐ Ulcerative colitis (UC)
   - ☐ Crohn's Disease (CD)
   - ☐ Psoriatic arthritis (PsA)
   - ☐ Ankylosing spondylitis (AS), or Peripheral/Axial spondyloarthritis (seronegative spondyloarthropathy)
   - ☐ Juvenile idiopathic arthritis (JIA) – polyarticular, oligoarticular, or systemic
   - ☐ Hidradenitis suppurativa
   - ☐ Behcet's Disease
   - ☐ Pyoderma gangrenosum
   - ☐ Non-infectious intermediate, posterior or panuveitis
   - ☐ Other: _____
2. What is the HCPCS code? _____ What is the ICD-10 code? _____
   What is the NDC#: _____
3. Will the requested drug be used in combination with any other biologic or targeted synthetic DMARD (e.g., Olumiant, Xeljanz)? ☐ Yes ☐ No
4. Has the patient had a TB screening test (e.g., a tuberculosis skin test [PPD] or an interferon-release assay [IGRA]) within 6 months of initiating therapy? ☐ Yes ☐ No
5. What were the results of the TB screening test? ☐ Positive ☐ Negative
6. Does the patient have latent or active tuberculosis (TB)? ☐ Latent ☐ Active ☐ No/Neither

7. If the patient has latent or active tuberculosis, has treatment been initiated or completed?
   ☐ Yes - treatment initiated ☐ Yes - treatment completed ☐ No

8. Is this request for continuation of therapy? ☐ Yes ☐ No If No, skip to diagnosis section.

9. For continuation of therapy requests, has the patient achieved or maintained positive clinical response as evidenced by low disease activity or improvement in signs and symptoms since starting treatment with the requested drug? ☐ Yes ☐ No

10. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program? ☐ Yes ☐ No

DIAGNOSIS SECTION ***Please only complete sections below that are relevant to the patient's diagnosis.***

Section A: Rheumatoid Arthritis

11. The patient has diagnosis of rheumatoid arthritis and the treatment is prescribed by or in consultation with a rheumatologist. ☐ Yes ☐ No

12. Has the patient previously received a biologic or targeted synthetic DMARD (e.g., Rinvoq, Xeljanz) that is indicated for moderately to severely active rheumatoid arthritis? ☐ Yes ☐ No If Yes, please indicate the drug, duration, response, and intolerance/contraindication if applicable:
    _____

* Please note, the preferred drug in this class is Cimzia, followed by Simponi. Please consider prescribing 1 of these drugs before Humira if clinically appropriately. If Humira is preferred over these 2 agents, please provide additional clinical reasoning documentation here:_____

13. Has the patient experienced an inadequate response after at least 3 months of treatment with methotrexate 25mg PO weekly* ? ☐ Yes ☐ No If the methotrexate dose is unable to be increased to 25mg PO weekly, please indicate reason: _____

14. Has the patient experienced intolerance to methotrexate? ☐ Yes ☐ No If Yes, indicate intolerance:
    _____

15. Does the patient have a contraindication to methotrexate? ☐ Yes ☐ No If Yes, indicate contraindication:
    _____

Section B: Juvenile Idiopathic Arthritis (polyarticular, oligoarticular, or systemic)

16. Has the patient previously received a biologic indicated for moderately to severely active articular juvenile idiopathic arthritis? ☐ Yes ☐ No If Yes, please indicate the drug, duration, response, and intolerance/contraindication if applicable:
    _____

17. Has the patient had an inadequate response to methotrexate or another non-biologic DMARD administered at an adequate dose and duration? ☐ Yes ☐ No

18. Does the patient have any of the following risk factors: a) positive rheumatoid factor or anti-CCP, b) pre-existing joint damage, c) high disease activity or high risk for disabling joint disease? ☐ Yes ☐ No

Section C: Ankylosing Spondylitis, or Peripheral/Axial Spondyloarthritis (Seronegative Spondyloarthropathy)

19. The patient is diagnosed ankylosing spondylitis or peripheral/axial spondyloarthritis, and the treatment is prescribed by or in consultation with a rheumatologist. ☐ Yes ☐ No

20. Has the patient previously received a biologic indicated for active ankylosing spondylitis? ☐ Yes ☐ No
    If Yes, please indicate the drug, duration, response, and intolerance/contraindication if applicable:
    _____

* Please note, the preferred drug in this class is Cimzia, followed by Simponi. Please consider prescribing 1 of these drugs before Humira if clinically appropriately. If Humira is preferred over these 2 agents, please provide additional clinical reasoning documentation here:_____

21. Has the patient experienced an inadequate response with at least TWO nonsteroidal anti-inflammatory drugs (NSAIDs), or has an intolerance or contraindication to at least two NSAIDs? ☐ Yes ☐ No

Section D. Crohn's Disease

22. There is documentation of moderate to severe Crohn's disease per the Crohn's Disease Activity index (CDAI):
    - ☐ Mild = CDAI <220
    - ☐ Moderate = CDAI 220-450
    - ☐ Severe = CDAI >450

23. There is documentation of 1 or more of the following high-risk features:
    - ☐ Diagnosis at age <30 years
    - ☐ Ileal disease
    - ☐ Penetrating or stricturing disease
    - ☐ Perianal or severe rectal disease
    - ☐ Extra-intestinal manifestations
    - ☐ History of bowel resections
    - ☐ Initial extensive bowel involvement on endoscopy
    - ☐ None

24. The treatment is prescribed by or in consultation with a gastroenterologist ☐ Yes ☐ No

25. Has the patient previously received a biologic indicated for Crohn's disease? ☐ Yes ☐ No
    If Yes, please indicate the drug, duration, response, and intolerance/contraindication if applicable:
    _____

* Please note, the preferred drug in this class is Cimzia. Please consider prescribing this drug before Humira if clinically appropriately. If Humira is preferred, please provide additional clinical reasoning documentation here:
_____

26. Does the patient have perianal or fistulizing Crohn's disease? ☐ Yes ☐ No

27. Has the patient had an inadequate response to a minimum 3 month trial at the maximally indicated dose of 1 or more of the following therapies within the last 6 months? If Yes, indicate below and no further questions.
    - ☐ Sulfasalazine
    - ☐ Mesalamine (if primarily colonic disease)
    - ☐ Azathioprine at minimum dose 1.5 mg/kg daily
    - ☐ 6-mercaptopurine at minimum dose 50mg daily
    - ☐ Methotrexate at minimum dose 15mg **IM or SQ** weekly
    - ☐ Systemic corticosteroids (e.g., prednisone, methylprednisolone)
    - ☐ None of the above therapies have been trialed

28. Does the patient have a contraindication or intolerance to at least 2 options listed above? ☐ Yes ☐ No
    If yes, please document medications and respective contraindications/intolerances:
    _____

Section E: Ulcerative Colitis

29. There is a diagnosis of moderate to severe ulcerative as evidenced by one of the following:
    - ☐ >4 loose and/or bloody bowel movements per day
    - ☐ Evidence of systemic toxicity (e.g., fever, tachycardia, anemia with Hgb<10.0 g/dL, weight loss, and/or elevated CRP or ESR).

- ☐ Endoscopic findings of marked erythema, absent vascular pattern, friability, erosions, spontaneous bleeding, and/or ulceration (e.g., findings consistent with a Mayo endoscopic sub score of at least 2, or Ulcerative Colitis Endoscopic Index of Severity of at least 5)
- ☐ Patients with corticosteroid dependent or corticosteroid refractory disease
- ☐ Patients at high risk for colectomy with clinical documentation of risk by prescribing provider

30. The treatment is prescribed by or in consultation with a gastroenterologist ☐ Yes ☐ No

31. Has the patient previously received a biologic or targeted synthetic disease modifying drug (e.g., Xeljanz) indicated for moderately to severely active ulcerative colitis? ☐ Yes ☐ No
    If Yes, please indicate the drug, duration, response, and intolerance/contraindication if applicable:
    _____

* Please note, the preferred drug in this class is Simponi. Please consider prescribing this drug before Humira if clinically appropriately. If Humira is preferred over this drug, please provide additional clinical reasoning documentation here:
_____

32. Has the patient been hospitalized for acute severe ulcerative colitis (e.g., continuous bleeding, severe toxic symptoms, including fever and anorexia)? ☐ Yes ☐ No

33. Has the patient had an inadequate response to a minimum 2 month trial at the maximally indicated dose of 1 or more of the following within the last 6 months? If Yes, indicate below and no further questions.
    - ☐ Oral 5-aminosalycylic acid (e.g., sulfasalazine, mesalamine) at a minimum dose of 2g daily
    - ☐ Rectal 5-aminosalycylic acid enemas with minimum dose of 1g daily
      * Note: failure of rectal 5-ASA suppositories alone will not meet criteria for biologic
    - ☐ Budesonide
    - ☐ Thiopurines (e.g., azathioprine, 6-mercaptopurine)
    - ☐ Methotrexate with a minimum dose of 15mg IM or SQ weekly
    - ☐ Systemic corticosteroids (e.g., prednisone, methylprednisolone)
    - ☐ None of the above therapies have been trialed

34. Does the patient have a contraindication or intolerance to at least 2 options listed above? ☐ Yes ☐ No
    If yes, please document medications and respective contraindications/intolerances:
    _____

Section F: Psoriasis

35. The patient is diagnosed with psoriasis and treatment is prescribed by or in consultation with a dermatologist or rheumatologist ☐ Yes ☐ No

36. Has the patient previously received Otezla or any other biologic medication indicated for the treatment of moderate to severe plaque psoriasis? ☐ Yes ☐ No If Yes, please indicate the drug, duration, response, and intolerance/contraindication if applicable:
    _____

37. Has the patient had an inadequate response to 1 or more of the following topical therapies?
    - ☐ Corticosteroids (e.g., betamethasone, clobetasol, desonide) (4-week trial)
    - ☐ Vitamin D analogs (e.g., calcitriol, calcipotriene)
    - ☐ Tazarotene
    - ☐ Calcineurin inhibitors (e.g., tacrolimus, pimecrolimus)
    - ☐ Anthralin
    - ☐ Coal tar

38. Has the patient had an inadequate response to a minimum 3 month trial of methotrexate at a minimum dose of 15mg po weekly within the last 6 months? ☐ Yes ☐ No

39. Does the patient have a contraindication or intolerance to methotrexate? ☐ Yes ☐ No If Yes, indicate contraindication/intolerance and no further questions. _____

40. Does the patient have severe psoriasis that warrants a biologic DMARD as first-line therapy (i.e. at least 10% of the body surface area (BSA) or crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) are affected)? ☐ Yes ☐ No

Section G: Psoriatic Arthritis

41. The patient is diagnosed with psoriatic arthritis and treatment is prescribed by or in consultation with a rheumatologist ☐ Yes ☐ No

42. Has the patient previously received a biologic medication, apremilast (Otezla), or targeted synthetic DMARD (e.g., Xeljanz) indicated for the treatment of psoriatic arthritis? ☐ Yes ☐ No ☐ Yes ☐ No If Yes, please indicate the drug, duration, response, and intolerance/contraindication if applicable:
    _____

* Please note, the preferred drug in this class is Cimzia, followed by Simponi. Please consider prescribing 1 of these drugs before Humira if clinically appropriately. If Humira is preferred over these 2 agents, please provide additional clinical reasoning documentation here: _____

43. Has the patient experienced an inadequate response after at least 3 months of treatment with 1 or more of the following medications at the maximally tolerated dose?
    - ☐ Methotrexate – minimum dose 15mg po weekly
    - ☐ Sulfasalazine – minimum dose 2g po weekly
    - ☐ Cyclosporine
    - ☐ Leflunomide
    - ☐ Apremilast (Otezla)

44. Does the patient have a contraindication or intolerance to at least 2 options listed above? ☐ Yes ☐ No
    If yes, please document medications and respective contraindications/intolerances:
    _____

Section H: Hidradenitis Suppurativa

45. Has the patient previously received a biologic medication indicated for the treatment of moderate to severe hidradenitis suppurativa? ☐ Yes ☐ No If Yes, please indicate the drug, duration, response, and intolerance/contraindication if applicable:
    _____

46. Has the patient experienced an inadequate response after at least 3 months of treatment with oral antibiotics? ☐ Yes ☐ No

47. Has the patient experienced an intolerable adverse effect to oral antibiotics? ☐ Yes ☐ No

48. Does the patient have a contraindication to oral antibiotics? ☐ Yes ☐ No

Section I: Behcet's Disease

49. Has the patient received Otezla or a biologic indicated for the treatment of Behcet's disease? ☐ Yes ☐ No
    If Yes, please indicate the drug, duration, response, and intolerance/contraindication if applicable:
    _____

50. Has the patient had an inadequate response to at least one nonbiologic medication for Behcet's disease (apremilast, colchicine, systemic corticosteroids, azathioprine)? ☐ Yes ☐ No

Section J: Non-infectious posterior, intermediate, or pan- uveitis

51. Has the patient received a biologic indicated for the treatment of intermediate, posterior, or panuveitis?
☐ Yes ☐ No If Yes, please indicate the drug, duration, response, and intolerance/contraindication if applicable: _____

52. Has the patient experienced an inadequate response to systemic corticosteroids or immunosuppressive therapy (e.g., azathioprine, cyclosporine, methotrexate)? ☐ Yes ☐ No

53. Has the patient experienced an intolerance to systemic corticosteroids and immunosuppressive therapy (e.g., azathioprine, cyclosporine, methotrexate)? ☐ Yes ☐ No

54. Does the patient have a contraindication to systemic corticosteroids and immunosuppressive therapy (e.g., azathioprine, cyclosporine, methotrexate)? ☐ Yes ☐ No

Section K: Pyoderma Gangrenosum

55. Has the patient received a biologic indicated for the treatment of pyoderma gangrenosum? ☐ Yes ☐ No
If Yes, please indicate the drug, duration, response, and intolerance/contraindication if applicable:
_____

56. Has the patient experienced an inadequate response to systemic corticosteroids or immunosuppressive therapy (e.g., cyclosporine, mycophenolate mofetil)? ☐ Yes ☐ No

57. Has the patient experienced an intolerance to systemic corticosteroids and immunosuppressive therapy (e.g., cyclosporine, mycophenolate mofetil)? ☐ Yes ☐ No

58. Does the patient have a contraindication to systemic corticosteroids and immunosuppressive therapy (e.g., cyclosporine, mycophenolate mofetil)? ☐ Yes ☐ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by Sendero Health Plans.

Prescriber or Authorized Signature	DATE