

PRIOR AUTHORIZATION REQUEST FORM

HIDRADENITIS SUPPURATIVA

Hadlima™, Humira®, Cosentyx®

For authorization, please answer each question and fax this form PLUS chart notes back to Real Rx at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance 385-425-5094.

reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria. Product being requested: Preferred: ☐ Hadlima™ (adalimumab-bwwd), ☐ Humira® (adalimumab) Non-formulary: ☐ Cosentyx® (secukinumab) Dosing/Frequency:	DOE Offi	e:		dance wi	th Feder	al and State notice requirements.			
DOB: Gender: Office Phone: Office Phone: Height/Weight: Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment wit preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria. Product being requested: Preferred: ☐ Hadlima™ (adalimumab-bwwd), ☐ Humira® (adalimumab) Non-formulary: ☐ Cosentyx® (secukinumab) Dosing/Frequency:	DOE Offi	e:							
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	Dosing/Frequency:								
If the request is for reauthorization, proceed to reauthorization section									
Questions Yes No Comments/Notes		Questic	ons	Yes	No	Comments/Notes			
1. Is this request for an expedited review? By checking the "Yes" box to request an expedited review (24 hours), you are certifying that applying the standard review time frame (72 hours) may place the member's life, health, or ability to regain maximum function in serious jeopardy.		By checking the "Yes" box to req hours), you are certifying that ap frame (72 hours) may place the r	uest an expedited review (24 plying the standard review time nember's life, health, or ability						
		Does the member have a diagno	sis of moderate to severe			Please provide documentation			
3. Is the requesting provider a dermatologist or in consultation with a dermatologist?	2.								
4. Has smoking cessation, weight management, diet, and proper hygiene counseling been discussed with the member?			natologist or in consultation						
· · · · · · · · · · · · · · · · · · ·	3.	with a dermatologist? Has smoking cessation, weight m	anagement, diet, and proper			Please provide documentation			
	3. 4.	with a dermatologist? Has smoking cessation, weight many hygiene counseling been discussed. Has the member had an inadequent	nanagement, diet, and proper ed with the member? ate response to ≥ 90 day trial of			Please provide documentation Please provide documentation			
	3.4.5.	with a dermatologist? Has smoking cessation, weight many hygiene counseling been discussed. Has the member had an inadequency oral antibiotics, unless contrained. Have baseline inflammatory lesions.	nanagement, diet, and proper ed with the member? ate response to ≥ 90 day trial of icated?			·			
8. Has the provider performed hepatitis B screening prior to therapy initiation?	3.4.5.6.7.	with a dermatologist? Has smoking cessation, weight many hygiene counseling been discussed. Has the member had an inadequational antibiotics, unless contrained. Have baseline inflammatory lesion inflammatory nodules) and drained has the provider performed tubes.	nanagement, diet, and proper ed with the member? ate response to ≥ 90 day trial of icated? on count (abscesses + ing fistulas been documented?			Please provide documentation			

COSENTYX®							
1.	Has the member tried and failed, or have contraindication to an adalimumab product and an infliximab product?			Please provide documentation			
2.	Has baseline lesion count been documented?			Please provide documentation			
3.	If the request is for 300mg every 14 days, does documentation show the following: • Member has been compliant with 300 mg dosing every			Please provide documentation			
	 28 days for at least 16 weeks; AND Clinical documentation shows a positive, yet limited response to therapy? 						
	REAUTHORIZATION						
1.	Is the request for reauthorization of therapy?						
2.	Does clinical documentation show a response seen by week 16 of therapy of at least a 50% decrease in inflammatory lesion count (abscesses + inflammatory nodules) and no increase in abscesses or draining fistulas compared to baseline?			Please provide documentation			
3.	Has the provider performed continued tuberculosis monitoring during therapy?			Please provide documentation			
4.	Has the provider performed continued Hepatitis B monitoring in HBV carriers?			Please provide documentation			
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.							
	ditional information:						
Physician's Signature:							

** Failure to submit clinical documentation to support this request will result in a dismissal of the request.**

Policy: PHARM-032

Origination Date: 05/10/2018 Reviewed/Revised Date: 01/17/2024 Next Review Date: 01/17/2025 Current Effective Date: 02/01/2024

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