HEALTHY U CHIP

PRIOR AUTHORIZATION REQUEST FORM
ADALIMUMAB FOR UVEITIS

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U CHIP Prior Authorization Department 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

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:

Height/Weight:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred/Non-Formulary:

1. **1st Line Preferred Agents:**
   A. Hadlima™ (adalimumab-bwwd)
2. **2nd line preferred agents with single step; after trial and failure of Hadlima:**
   A. Humira® (adalimumab)

Product being requested: ☐ Hadlima™ (adalimumab-bwwd) ☐ Humira® (adalimumab)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Is the member 2 years of age or older?	☐	☐	
2. Is the requesting provider an ophthalmologist or in consultation with one?	☐	☐	
3. Has the member been diagnosed with non-infectious uveitis classified as intermediate, posterior, or panuveitis?	☐	☐	**Please provide documentation**
4. Has the member had a trial and failure of at least one systemic corticosteroid at the maximum indicated dose within the past 3 months?	☐	☐	**Please provide documentation**
5. Has the member had a trial and failure of at least one systemic non-biologic immunosuppressant (methotrexate, cyclosporine, azathioprine, mycophenolate, etc.) within the last 3 months?	☐	☐	**Please provide documentation**
6. Will Hadlima or Humira be used in combination with any other biologic or small molecule DMARD (Xeljianz, Otezla, etc.)?	☐	☐	
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	

2. Does documentation show a positive clinical response to treatment?	☐	☐	**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.
Additional information:
Physician Signature:

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Policy: PHARM-CHIP-101
Origination Date: 07/01/2024
Reviewed/Revised Date:
Next Review Date:
Current Effective Date: 07/01/2024