REALRx

# 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.

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: | | HCPCS Code: |

***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.***

**Product being requested:**
**Preferred:** ☐ Hadlima™ (adalimumab-bwwd), ☐ Humira® (adalimumab)
**Non-formulary:** ☐ Cosentyx® (secukinumab)

Dosing/Frequency:_____

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

| Questions | 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. | ☐ | ☐ | |
| 2. Does the member have a diagnosis of moderate to severe (Hurley Stage II or III) Hidradenitis Suppurativa? | ☐ | ☐ | **Please provide documentation** |
| 3. Is the requesting provider a dermatologist or in consultation with a dermatologist? | ☐ | ☐ | |
| 4. Has smoking cessation, weight management, diet, and proper hygiene counseling been discussed with the member? | ☐ | ☐ | **Please provide documentation** |
| 5. Has the member had an inadequate response to ≥ 90 day trial of oral antibiotics, unless contraindicated? | ☐ | ☐ | **Please provide documentation** |
| 6. Have baseline inflammatory lesion count (abscesses + inflammatory nodules) and draining fistulas been documented? | ☐ | ☐ | **Please provide documentation** |
| 7. Has the provider performed tuberculosis (TB) screening prior to therapy initiation? | ☐ | ☐ | **Please provide documentation** |
| 8. Has the provider performed hepatitis B screening prior to therapy initiation? | ☐ | ☐ | **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:<br>• Member has been compliant with 300 mg dosing every 28 days for at least 16 weeks; AND<br>• Clinical documentation shows a positive, yet limited response to therapy? | ☐ | ☐ | **Please provide documentation** |
| **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.** | | | |
| Additional 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