

# 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. **1<sup>st</sup> Line Preferred Agents:**
  - A. Hadlima™ (adalimumab-bwwd), Simlandi® (adalimumab-ryvk)
2. **2nd line preferred agents with single step; after trial and failure of Hadlima or Simlandi:**
  - A. Humira® (adalimumab)

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

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?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the requesting provider an ophthalmologist or in consultation with one?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Has the member been diagnosed with non-infectious uveitis classified as intermediate, posterior, or panuveitis?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
6. Will Hadlima, Humira, or Simlandi be used in combination with any other biologic or small molecule DMARD (Xeljanz, Otezla, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	

### REAUTHORIZATION

1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does documentation show a positive clinical response to treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>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.</b>			
Additional information:			
Physician Signature:			

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

Policy: PHARM-CHIP-101  
Origination Date: 07/01/2024  
Reviewed/Revised Date: 09/18/2024  
Next Review Date: 9/18/2024  
Current Effective Date: 10/01/2024

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