Fax completed form to Navitus at: 855-668-8553
For questions, please call: 877-908-6023

TEXAS MEDICAID

Drug Prior Authorization
Cytokine and CAM Antagonists: adalimumab (HUMIRA) and Biosimilar Agents

Request Information (required)
This request is: ☐ **Expedited* (Urgent)** ☐ **Standard (Non-Urgent)** *Expedited means the standard review time may seriously harm the member's life, health, or ability to regain maximum function.

Member Information (required)			Prescriber Information (required)		
Member Name:			Prescriber Name:		
Member Insurance ID #:			NPI # :	Specialty:	
Date of Birth:			Office Phone:		
Member Phone:			Office Fax:		
Member Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:

Please fill out the following information:

1. Medication Requested (Name):
(Go to #2)

2. Quantity Requested:
(Go to #3)

3. Dose Requested (Strength):
(Go to #4)

4. Dosing Instructions:
(Go to #5)

Required Criteria

5. Provide primary diagnosis including ICD-10 code(s):
(Go to #6)

6. Please indicate the requested drug's formulary status: *(Formulary available at www.txvendordrug.com)

- ◯ Non-Preferred Drug (NPD or NAP)
  (Go to #7)
- ◯ Preferred Drug (PDL)
  (Go to #10)
- ◯ No Status, Drug is not in a Market Basket
  (Go to #10)
- ◯ N/A as this request is for a CHIP/PERINATE member
  (Go to #10)

Preferred Drug List (PDL) Criteria (required for non-preferred products)

7. Has the member failed a 30-day treatment trial with at least one (1) preferred agent in the last 180 days?

- ◯ Yes
  (Go to #10)
- ◯ No
  (Go to #8)

8. Is there a documented allergy or contraindication to preferred agents in this class?

- ◯ Yes
  (Go to #10)
- ◯ No
  (Go to #9)

9. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?

- ◯ Yes
  (Go to #10)
- ◯ No (Deny)
  (Go to #10)

Clinical Criteria (required)

10. Does the member have a diagnosis of Psoriatic Arthritis (PsA) and/or Plaque Psoriasis (Ps) in the last 730 days?

- ◯ Yes (Go to #16)
- ◯ No (Go to #11)

11. Does the member have a diagnosis of Ankylosing Spondylitis (AS) and/or Rheumatoid Arthritis (RA) in the last 730 days?

- ◯ Yes (Go to #17)
- ◯ No (Go to #12)

12. Does the member have a diagnosis of Ulcerative Colitis (UC) in the last 730 days?

- ◯ Yes (Go to #20)
- ◯ No (Go to #13)

13. Does the member have a diagnosis of Crohn's Disease in the last 730 days?

- ◯ Yes (Go to #21)
- ◯ No (Go to #14)

14. Does the member have a diagnosis of Juvenile Idiopathic Arthritis (JIA) and/or Uveitis (UV) in the last 730 days?

- ◯ Yes (Go to #19)
- ◯ No (Go to #15)

15. Does the member have a diagnosis of Hidradenitis Suppurativa (HS) in the last 730 days?

- ◯ Yes (Go to #18)
- ◯ No (Deny) (Go to #18)

16. Is the member greater than or equal to (≥) 4 years of age?

- ◯ Yes (Go to #24)
- ◯ No (Deny) (Go to #24)

17. Is the member greater than or equal to (≥) 18 years of age?

- ◯ Yes (Go to #24)
- ◯ No (Deny) (Go to #24)

18. Is the member greater than or equal to (≥) 12 years of age?

- ◯ Yes (Go to #24)
- ◯ No (Deny) (Go to #24)

19. Is the member greater than or equal to (≥) 2 years of age?

- ◯ Yes (Go to #24)
- ◯ No (Deny) (Go to #24)

20. Is the member greater than or equal to (≥) 5 years of age?

- ◯ Yes
  (Go to #22)
- ◯ No (Deny)
  (Go to #22)

21. Is the member greater than or equal to (≥) 6 years of age?

- ◯ Yes
  (Go to #22)
- ◯ No (Deny)
  (Go to #22)

22. Has the member had at least a 30-day trial with conventional therapy in the last 180 days?

Examples of conventional therapy for CD or UC include azathioprine (IMURAN), cyclosporine (GENGRAF, NEORAL, SANDIMMUNE), dexamethasone, hydrocortisone (CORTEF), mercaptopurine (PURIXAN), methotrexate (OTREXUP, TREXALL, XATMEP), methylprednisolone (MEDROL), prednisolone (MILLIPRED, VERIPRED), and prednisone.

- ◯ Yes
  (Go to #24)
- ◯ No
  (Go to #23)

23. Is the request for continuing therapy with adalimumab?

- ◯ Yes
  (Go to #24)
- ◯ No (Deny)
  (Go to #24)

24. Does the member have a history of heart failure in the last 365 days?

- ◯ Yes (Deny)
  (Go to #25)
- ◯ No
  (Go to #25)

25. Does the member have a history of demyelinating disease (multiple sclerosis, optic neuritis, and/or Guillain -Barre syndrome) in the last 365 days?

- ◯ Yes (Deny)
  (Go to #26)
- ◯ No
  (Go to #26)

26. Does the member have a history of hematologic abnormalities such as aplastic anemia, pancytopenia, thrombocytopenia, neutropenia, or decreased white blood cell counts in the last 180 days?

- ◯ Yes (Deny)
  (Go to #27)
- ◯ No
  (Go to #27)

27. Does the member have a serious active infection (including Hepatitis B virus and/or tuberculosis) in the last 180 days?

- ◯ Yes (Deny)
  (Go to #28)
- ◯ No
  (Go to #28)

28. Does the member have one (1) claim for another tumor necrosis factor (TNF) Blocker (other than adalimumab) in the last 30 days?

    Examples of other TNF Blockers are: certolizumab pegol (CIMZIA), etanercept (ENBREL), and golimumab (SIMPONI).

- ◯ Yes (Deny)
  (Go to #29)
- ◯ No (Approve - 365 days)
  (Go to #29)

Additional Information

29. Please provide any additional information we should consider (or attach any supporting documents):
(END)

Submission Information (required)

Prescriber Signature: _____ **Date:** _____

**** PLEASE FAX COMPLETED FORM TO: 855-668-8553 ****

If criteria not met, submit chart documentation with form citing complex medical circumstances.
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