**Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.**
**Humira and adalimumab Biosimilars Prior Authorization (PA)**
**Pharmacy Benefits Prior Authorization Help Desk**
**Length of Authorizations: Initial- 12 months; Continuation- 12 months**

**Instructions:**

This form is used by Kaiser Permanente and/or participating providers for coverage of **Humira and Adalimumab Biosimilars** for **VA Medicaid** plans**.** Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours (fax: 1-866-331-2104). If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless all sections are complete.**

**KP-MAS Formulary can be found at:** Pharmacy | Community Provider Portal | Kaiser Permanente

**Medications:**

- **adalimumab-adbm***
- **Hadlima*** (adalimumab-bwwd)
- **Abrilada***** (adalimumab-afzb)
- **Simlandi***** (adalimumab-ryvk) + unbranded adalimumab-ryvk
- **Yuflyma***** (adalimumab-aaty) + unbranded adalimumab-aaty
- **Cyltezo***** (adalimumab-adbm) + unbranded adalimumab-adbm
- **Hulio***** (adalimumab-fkjp) + unbranded adalimumab-fkjp
- **Hyrimoz***** (adalimumab-adaz) + unbranded adalimumab-adaz
- **Idacio***** (adalimumab-aacf) + unbranded adalimumab-aacf
- **Yusimry***** (adalimumab-aqvh)
- **Humira** (adalimumab)
- **Amjevita***** (adalimumab atto)

**1 – Patient Information**

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

**2 – Prescriber Information**

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

Do you have an approved provider referral number from Kaiser Permanente?
□ Yes – please provide your provider referral number here: _____

**3 – Pharmacy Information**

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

**4 – Drug Therapy Requested**

Drug 1: Name/Strength/Formulation: _____

Sig: _____

Drug 2: Name/Strength/Formulation: _____

Sig: _____

**5– Diagnosis/Clinical Criteria**

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, state start date: _____

**Clinical Criteria:**

1. The patient has a diagnosis of an FDA-approved indication for the requested therapy (Select diagnosis)? AND,

□ Adult rheumatoid arthritis (RA)
□ Juvenile idiopathic arthritis (JIA)
□ Adult psoriatic arthritis (PsA)
□ Adult ankylosing spondylitis (AS)
□ Adult Crohn's disease (CD)
□ Pediatric Crohn's disease
□ Adult ulcerative colitis (UC)
□ Pediatric ulcerative colitis
□ Adult Plaque psoriasis (Ps)
□ Hidradenitis suppurativa (HS): age ≥12 years□ Adult Uveitis (UV), noninfectious
□ Pediatric uveitis, (UV) noninfectious

□ No □ Yes

*If the request is for the preferred products, adalimumab-adbm* or Hadlima*, no further questions are needed. Complete section 6 and fax the form.

**Additional questions for NON-Preferred agent, Humira****

2. Has the patient tried and failed or had contraindication to two preferred Humira biosimilar agents (adalimumab-adbm and Hadlima) or ?
   □ No □ Yes

**All other NON-Preferred Agents***: Abrilada; Amjevita; Cyltezo; adalimumab-fkjp, Hulio; adalimumab-adaz, Hyrimoz; adalimumab-aacf, Idacio; adalimumab-ryvk, Simlandi; adalimumab-aaty, Yuflyma**

3. Has the patient tried and failed or had contraindication to two preferred Humira biosimilar agents (adalimumab-adbm and Hadlima, Enbrel)?
   □ No □ Yes

**6 – Prescriber Sign-Off**

**Additional Information –**

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**

2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____

_____

_____

**I certify that the information provided is accurate. Supporting documentation is available for State audits.**

| **Prescriber Signature:** | **Date:** |
|---|---|
| | |