United Healthcare Community Plan

COMMONWEALTH OF VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Service Authorization (SA) Form

Non-Preferred Cytokine and CAM Antagonists and Related Agents

If the following information is not complete, correct, or legible, the SA process can be delayed.

Please use one form per member.

MEMBER INFORMATION

Last Name: _____

First Name: _____

Medicaid ID Number: _____

Date of Birth: _____

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name: _____

First Name: _____

NPI Number: _____

Phone Number: _____

Fax Number: _____

DRUG INFORMATION

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

DIAGNOSIS AND MEDICAL INFORMATION

Does the member meet the following criteria?

1. Does the member have a diagnosis of an FDA-approved indication for the requested product? Please list the indication below.

   ☐ Yes ☐ No

   Indication: _____

2. For brand **HUMIRA**:
   Has the member tried and failed TWO preferred biosimilar agents for Humira? In addition, an **FDA Medwatch form must be completed** for both preferred adalimumab biosimilar products and a copy of submitted MedWatch form must be attached for approval consideration.

   ☐ Yes ☐ No

3. For brand **STELARA**:
   Has the member tried and failed one preferred biosimilar agent for Humira and the preferred biosimilar agent for Stelara? In addition, an **FDA Medwatch form must be completed** and a copy of submitted MedWatch form for the preferred ustekinumab biosimilar product must be attached for approval consideration.

   ☐ Yes ☐ No

4. For all other requests, does the member have a therapeutic failure of two preferred agents?

   ☐ Yes ☐ No

   If **Yes**, provide details of failure:

   _____

5. What is the medical necessity that supports the use of the requested medication (provide clinical evidence)?

   _____

For additional information and criteria related to non-preferred agents, please refer to Appendix A and submit supporting documentation.

Prescriber Signature (Required) **Date**

By signature, the physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; incomplete forms will delay the SA process.

Submission of documentation does NOT guarantee coverage by the Department of Medical Assistance Services.

Fax this form to 1-866-940-7328

Pharmacy PA Call Center 1-800-310-6826