Premier Health Plan
Pharmacy Services
Commercial Phone: 855-266-0713
Exchange Phone: 866-822-2413
Fax: 855-862-6518

HUMIRA
Prior Authorization Form

□ Standard Request □ Expedited Request	If you or your prescriber believe that waiting for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. ***For state exchanges only:*** The above disclaimer applies for exigent circumstances. Expedited review may also be requested when you are undergoing a current course of treatment using a non-formulary drug.

Demographics

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
DOB:	Age:	NPI#:	Specialty:
Health Plan ID#:		Phone:	Fax:
Pharmacy Name:	Pharmacy Phone:	Office Contact:	Direct Phone # or Ext:

Medication Information

Drug Requested: Humira	Strength: □ 40mg/0.8ml Pre-Filled Syringe Kit □ 40mg/0.8ml Pre-Filled Pen Kit □ 40mg/0.8ml Pre-Filled Pen Kit Psoriasis Starter □ 40mg/0.8ml Pre-Filled Pen Kit Crohns Starter □ 10mg/0.2ml Pre-Filled Syringe Kit (Pediatric) □ 20mg/0.4ml Pre-Filled Syringe Kit (Pediatric)	Directions:	
		Quantity Dispensed:	Day Supply:
□ New medication □ Continuation of therapy	Start Date:	If this is continuation of therapy, please provide CHART DOCUMENTATION indicating the member showed improvement while on therapy.	

Clinical Information

Disease Severity:
□ Mild
□ Moderate
□ Severe

PPD (tuberculin) test:
□ Positive
□ Negative
Date:_____

Is the member currently using another TNF-blocking or biologic agent in combination with Enbrel? □ Yes □ No
Medication:_____

Does the member currently have evidence of infection? □ Yes □ No

Please indicate the diagnosis on the left and complete the corresponding questions.

□Rheumatoid Arthritis

OR

□Juvenile Idiopathic Arthritis

Has the member tried and failed Methotrexate for at least 3 months? □Yes □No

Please indicate if the member tried and failed any of the following for at least *3 months*

Medication	Dates on Therapy	Dose	Reason for Discontinuing
□Methotrexate			
□Leflunomide (Arava)			
□Sulfasalazine (Azulfidine)			
□Minocycline (Minocin)			
□Hydroxychlorquine (Plaquenil)			

□ Psoriatic Arthritis

Is the members disease dominant: □ Peripheral □ Axial

Has the member tried and failed any NSAIDs for at least 3 months? □Yes □No

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Member Name:	DOB:	Health Plan ID:
Please be sure to complete and include this page with the 1st page of this form.		

☐ Psoriatic Arthritis

Please indicate if the member tried and failed any of the following for at least *3 months*

Medication	Dates on Therapy	Dose	Reason for Discontinuing
☐NSAIDs			
☐Methotrexate			
☐ Cyclosporine (Neoral, Sandimmune)			
☐Sulfasalazine (Azulfidine)			
☐ Leflunomide (Arava)			

☐ Ankylosing Spondylosis

Is the members disease dominant: ☐ Peripheral ☐ Axial
Has the member tried and failed any NSAIDs for at least 3 months? ☐Yes ☐No

Please indicate if the member tried and failed any of the following for at least *3 months*

Medication	Dates on Therapy	Dose	Reason for Discontinuing

☐ Plaque Psoriasis

Has the member tried and failed any topical treatment? ☐Yes ☐No
Does the member have psoriasis on the palms, soles, head, neck, or genitalia? ☐Yes ☐No
Has the member tried and failed phototherapy or photochemotherapy? ☐Yes ☐No
Please indicate body surface area (BSA) involvement: ☐Less than 10% ☐Greater than or equal to 10%

Please indicate if the member tried and failed any of the following for at least *3 months*?

Medication	Dates on Therapy	Dose	Reason for Discontinuing
☐Topical:_____			
☐Methotrexate			
☐ Cyclosporine (Neoral, Sandimmune)			
☐ Acitretin (Soriatane)			

☐ Crohn's Disease

Has the member tried and failed corticosteroids? ☐Yes ☐No

Please indicate if the member tried and failed any of the following for at least *3 months*

Medication	Dates on Therapy	Dose	Reason for Discontinuing
☐Azathioprine (Imuran)			
☐6-mercaptopurine (Purinethol)			
☐Other Please list drug name:			

☐ Ulcerative Colitis

Has the member tried and failed corticosteroids? ☐Yes ☐No

Please indicate if the member tried and failed any of the following for at least *3 months*

Medication	Dates on Therapy	Dose	Reason for Discontinuing
☐Sulfasalazine (Azulfidine)			
☐Azathioprine (Imuran)			
☐Mesalamine (Asacol)			
☐6-mercaptopurine (Purinethol)			
☐Other Please list drug name:			