

HUMIRA Prior Authorization Form

<input type="checkbox"/> Standard Request (72 hours) <input type="checkbox"/> Expedited Request (24 hours)	If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. For expedited requests you will receive a decision within 24 hours. You cannot request an expedited coverage determination if you are requesting reimbursement for a drug you already received.
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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: <div style="text-align: center; font-weight: bold; font-size: 1.2em;">Humira</div>	Strength: <input type="checkbox"/> 40mg/0.8ml Pre-Filled Syringe Kit <input type="checkbox"/> 40mg/0.8ml Pre-Filled Pen Kit <input type="checkbox"/> 40mg/0.8ml Pre-Filled Pen Kit Psoriasis Starter <input type="checkbox"/> 40mg/0.8ml Pre-Filled Pen Kit Crohns Starter <input type="checkbox"/> 10mg/0.2ml Pre-Filled Syringe Kit (Pediatric) <input type="checkbox"/> 20mg/0.4ml Pre-Filled Syringe Kit (Pediatric)	Directions: <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Quantity Dispensed:</td> <td style="width: 50%;">Day Supply:</td> </tr> </table>	Quantity Dispensed:	Day Supply:
Quantity Dispensed:	Day Supply:			
<input type="checkbox"/> New medication <input type="checkbox"/> 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: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	PPD (tuberculin) test: <input type="checkbox"/> Positive <input type="checkbox"/> Negative Date: _____	Is the member currently using another TNF-blocking or biologic agent in combination with Humira? <input type="checkbox"/> Yes <input type="checkbox"/> No Medication: _____
Does the member currently have evidence of infection? <input type="checkbox"/> Yes <input type="checkbox"/> No		

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

<input type="checkbox"/> Rheumatoid Arthritis <div style="text-align: center;">OR</div> <input type="checkbox"/> Juvenile Idiopathic Arthritis	Has the member tried and failed Methotrexate with an inadequate response? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please fill out chart with other drug trials		
Please indicate if the member tried and failed any of the following			
Medication	Dates on Therapy	Dose	Reason for Discontinuing
<input type="checkbox"/> Leflunomide			
<input type="checkbox"/> Sulfasalazine			
<input type="checkbox"/> Hydroxychlorquine			
<input type="checkbox"/> Psoriatic Arthritis	Is the member's disease dominant: <input type="checkbox"/> Peripheral <input type="checkbox"/> Axial, skin, nail, enthesitis, dactylitis Has the member tried and failed NSAIDs (trial of 1 required for peripheral disease and 2 for axial, nail, enthesitis, dactylitis)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Please indicate if the member tried and failed any of the following			
Medication	Dates on Therapy	Dose	Reason for Discontinuing

	<input type="checkbox"/> NSAIDs (please specify agent(s))			
	<input type="checkbox"/> Methotrexate			
	<input type="checkbox"/> Cyclosporine			
	<input type="checkbox"/> Sulfasalazine (Azulfidine)			
	<input type="checkbox"/> Leflunomide (Arava)			
<input type="checkbox"/> Ankylosing Spondylosis	Is the members disease dominant: <input type="checkbox"/> Peripheral <input type="checkbox"/> Axial Has the member tried and failed at least 2 NSAIDs? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Please indicate any drug trials			
	Medication	Dates on Therapy	Dose	Reason for Discontinuing
<input type="checkbox"/> Plaque Psoriasis	Has the member tried and failed any topical treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Does the member have psoriasis on the palms, soles, head, neck, or genitalia? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Has the member tried and failed phototherapy or photochemotherapy? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Please indicate body surface area (BSA) involvement: <input type="checkbox"/> Less than 5% <input type="checkbox"/> Greater than or equal to 5%			
	Please indicate if the member tried and failed any of the following			
	Medication	Dates on Therapy	Dose	Reason for Discontinuing
<input type="checkbox"/> Topical: _____				
<input type="checkbox"/> Methotrexate				
<input type="checkbox"/> Cyclosporine				
<input type="checkbox"/> Acitretin				
<input type="checkbox"/> Crohn's Disease <i>OR</i> <input type="checkbox"/> Ulcerative Colitis	Has the member tried and failed corticosteroids? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Please indicate if the member tried and failed any of the following			
	Medication	Dates on Therapy	Dose	Reason for Discontinuing
	<input type="checkbox"/> 5-ASA (mesalamine, balsalazide, olsalazine, sulfasalazine – please specify agent(s))			
	<input type="checkbox"/> Immunosuppressant (please specify agent)			
<input type="checkbox"/> Other (please specify)				
<input type="checkbox"/> Hidradentitis suppurativa (HS)	Does the member have moderate or severe disease (with 3 active abscesses, inflammatory nodules, or lesions)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Please provide any additional information which should be considered in the space below:				