PRIOR AUTHORIZATION REQUEST
Humira

PATIENT: Name_____
Address: _____
City, State, Zip_____
D.O.B. _____
Member ID:_____

Prescriber: Name_____
Address _____
City, State, Zip_____
Phone _____
Fax _____
NPI _____

Medication Requested:_____ Qty Requested: _____

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please answer the following questions

1. Will the requested medication be used in combination with a BIOLOGIC or Targeted Synthetic disease-modifying antirheumatic drug?
   - ☐ Biologic DMARD
   - ☐ Targeted synthetic DMARD
   - ☐ Conventional synthetic DMARD
   - ☐ No, the requested medication will NOT be used in combination with another BIOLOGIC or Targeted Synthetic disease-modifying antirheumatic drug (DMARD)
2. ☐ Yes ☐ No Is the patient currently receiving an adalimumab product?
3. What is the diagnosis/ indication for use?
   - ☐ Rheumatoid arthritis **– Please answer questions 5, 6, 9 & 37**
   - ☐ Other – **Please answer question 4**
4. What is the indication or diagnosis?
   - ☐ Ankylosing spondylitis – **Please answer questions 9 & 38**
   - ☐ Crohn's disease – **Please answer questions 23, 27, 30, 31, 41 & 44**
   - ☐ Juvenile idiopathic arthritis (JIA) or Juvenile rheumatoid arthritis (JRA), (regardless of type of onset) (This includes patients with juvenile spondyloarthropathy/active sacroiliac arthritis) **– Please answer questions 9, 20, 26, 29 & 40**
   - ☐ Plaque psoriasis – **Please answer questions 15, 18, 24, 28 & 41**
   - ☐ Psoriatic arthritis (PsA) – **Please answer question 42**
   - ☐ Psoriatic arthritis – **Please answer questions 8, 42**
   - ☐ Ulcerative colitis – **Please answer questions 19, 25, 43 & 44**
   - ☐ Hidradenitis suppurativa – **Please answer questions 18, 21 & 41**
   - ☐ Uveitis (including other posterior uveitides and panuveitis syndromes) – **Please answer questions 7, 22 & 47**
   - ☐ Spondyloarthritis (SpA), other subtypes (for example, undifferentiated arthritis, non-radiographic

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axial SpA, reactive arthritis [Reiter's disease], arthritis associated with inflammatory bowel disease [IBD]) [NOTE: For AS or PsA, refer to the respective criteria above] – **Please answer questions 9 – 14 & 38**

- ☐ Behcet's disease – **Please answer questions 16, 32, 45 & 46**
- ☐ Pyoderma gangrenosum – **Please answer questions 17, 18 & 46**
- ☐ Sarcoidosis – **Please answer questions 33 – 35 & 46**
- ☐ Scleritis or sterile corneal ulceration **– Please answer questions 22, 36 & 48**
- ☐ Polymyalgia rheumatica (PMR)
- ☐ All other indications or diagnoses – Please specify _____

5. ☐ Yes ☐ No Has the patient tried one conventional synthetic disease-modifying antirheumatic drug (DMARD) for at least 3 months?
6. ☐ Yes ☐ No Has the patient tried at least one biologic for at least 3 months?
7. ☐ Yes ☐ No Has the patient tried one of the following therapies: periocular, intraocular, or systemic corticosteroids; immunosuppressives, or an etanercept or an infliximab product for uveitis?
8. ☐ Yes ☐ No Is the requested medication prescribed by or in consultation with a rheumatologist or a dermatologist?
9. ☐ Yes ☐ No Is the requested medication prescribed by or in consultation with a rheumatologist?
10. ☐ Yes ☐ No Does the patient have arthritis primarily in the knees, ankles, elbows, wrists, hands and/or feet?
11. ☐ Yes ☐ No Has the patient tried at least ONE conventional synthetic DMARD?
12. ☐ Yes ☐ No Does the patient have axial spondyloarthritis?
13. ☐ Yes ☐ No Does the patient have objective signs of inflammation, defined as: a C-reactive protein (CRP) elevated beyond the upper limit of normal for the reporting laboratory?
14. ☐ Yes ☐ No Does the patient have objective signs of inflammation, defined as: sacroiliitis reported on magnetic resonance imaging (MRI)?
15. ☐ Yes ☐ No Has the patient tried at least one traditional systemic agent for psoriasis for at least 3 months, unless intolerant?
16. ☐ Yes ☐ No Has the patient tried at least ONE conventional therapy or at least one tumor necrosis factor inhibitor?
17. ☐ Yes ☐ No Has the patient tried one other immunosuppressant for at least 2 months or was intolerant to one of these agents OR tried one systemic corticosteroid?
18. ☐ Yes ☐ No Is the requested medication prescribed by or in consultation with a dermatologist?
19. ☐ Yes ☐ No Has the patient had a trial of one systemic agent or a corticosteroid for ulcerative colitis?
20. ☐ Yes ☐ No Has the patient tried one other agent for this condition or will be starting on the requested medication concurrently with methotrexate, sulfasalazine, or leflunomide?
21. ☐ Yes ☐ No Has the patient tried ONE other therapy?
22. ☐ Yes ☐ No Is the requested medication prescribed by or in consultation with an ophthalmologist?

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23. □ Yes □ No Has the patient tried one other agent for Crohn's disease?
24. □ Yes □ No Has the patient already had a 3-month trial or previous intolerance to at least one biologic?
25. □ Yes □ No Does the patient have pouchitis AND has tried therapy with an antibiotic, probiotic, corticosteroid enema, or Rowasa (mesalamine) enema?
26. □ Yes □ No Does the patient have an absolute contraindication to methotrexate, suflasalazine, or leflunomide?
27. □ Yes □ No Has the patient tried corticosteroids, or is currently on corticosteroids, or are corticosteroids contraindicated in this patient?
28. □ Yes □ No Does the patient have a contraindication to methotrexate, as determined by the prescriber?
29. □ Yes □ No Does the patient have aggressive disease as determined by the prescriber?
30. □ Yes □ No Does the patient have enterocutaneous (perianal or abdominal) or rectovaginal fistulas?
31. □ Yes □ No Has the patient had ileocolonic resection (to reduce the chance of Crohn's disease recurrence)?
32. □ Yes □ No Does the patient have ophthalmic manifestations of Behcet's disease?
33. □ Yes □ No Has the patient tried at least ONE corticosteroid for this condition?
34. □ Yes □ No Has the patient tried at least one immunosuppressive agent, an infliximab product, chloroquine, or thalidomide?
35. □ Yes □ No Is the requested medication prescribed by or in consultation with a pulmonologist, ophthalmologist, or dermatologist?
36. □ Yes □ No Has the patient tried ONE other therapy for this condition?
37. □ Yes □ No Has the patient had a response, as determined by the prescriber?
38. □ Yes □ No Has the patient had a response, as determined by the prescriber?
39. □ Yes □ No Has the patient had a response to an adalimumab product, as determined by the prescriber?
40. □ Yes □ No Has the patient had a response, as determined by the prescriber?
41. □ Yes □ No Has the patient had a response to an adalimumab product, as determined by the prescriber?
42. □ Yes □ No Has the patient had a response, as determined by the prescriber?
43. □ Yes □ No Has the patient had a response, as determined by the prescriber?
44. □ Yes □ No Is the requested medication prescribed by or in consultation with a gastroenterologist?
45. □ Yes □ No Is the requested medication prescribed by or in consultation with a rheumatologist, dermatologist, ophthalmologist, gastroenterologist, or neurologist?
46. □ Yes □ No Has the patient responded to therapy, as determined by the prescriber?
47. □ Yes □ No Has the patient responded to therapy, as determined by the prescriber?
48. □ Yes □ No Has the patient responded to therapy, as determined by the prescriber?

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Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

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If you have any questions, call: 800-753-2851