PRIOR AUTHORIZATION REQUEST

ADALIMUMAB PRODUCTS

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

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 note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Is the request an INITIAL or CONTINUATION of therapy? [] Initial (If checked, go to 8) [] Continuation (If checked, go to 2)		
2	Will the requested medication be used in combination with other biologics? [Note: Examples of biologics include but not limited to adalimumab SC products (for example, Humira, biosimilars), Actemra (IV or SC), Cimzia, Cosentyx, an	Yes	No

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	etanercept SC product (for example, Enbrel, biosimilars), Ilumya, Skyrizi, Kevzara, Kineret, Orencia (IV or SC), an infliximab IV product (Remicade, biosimilars), a rituximab IV product (for example, Rituxan, biosimilars), Siliq, Stelara (IV or SC), Taltz, Tremfya, Entyvio, or Simponi (Aria or SC).] [If yes, no further questions.]		
3	Is the patient currently receiving the requested medication? [If no, skip to question 8.]	Yes	No
4	Has the patient been receiving medication samples of the requested medication? [If yes, skip to question 8.]	Yes	No
5	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 8.]	Yes	No
6	Has the patient been established on therapy for at least 3 months? [If no, skip to question 8.]	Yes	No
7	Has documentation been submitted to confirm that the patient has had a clinically significant response, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
8	Will the requested medication be used in combination with other biologics? [Note: Examples of biologics include but not limited to adalimumab SC products (for example, Humira, biosimilars), Actemra (IV or SC), Cimzia, Cosentyx, an etanercept SC product (for example, Enbrel, biosimilars), Ilumya, Skyrizi, Kevzara, Kineret, Orencia (IV or SC), an infliximab IV product (Remicade, biosimilars), a rituximab IV product (for example, Rituxan, biosimilars), Siliq, Stelara (IV or SC), Taltz, Tremfya, Entyvio, or Simponi (Aria or SC).] [If yes, no further questions.]	Yes	No
9	Is the request for a formulary adalimumab product? [If yes, skip to question 11.]	Yes	No
10	Does the patient have documented intolerance, contraindication to, or failed treatment for at least 3 months with preferred adalimumab product(s)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
11	What is the indication or diagnosis? [] Rheumatoid Arthritis (If checked, go to 12)		

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[] Ankylosing Spondylitis (If checked, go to 16)

[] Crohn's Disease (If checked, go to 19)

[] Juvenile Idiopathic Arthritis or Juvenile Rheumatoid Arthritis (regardless of type of onset) [Note: This includes patients with juvenile spondyloarthropathy/active sacroiliac arthritis.] (If checked, go to 27)

[] Hidradenitis Suppurativa (If checked, go to 34)

[] Plaque Psoriasis (If checked, go to 38)

[] Psoriatic Arthritis (If checked, go to 42)

[] Ulcerative Colitis (If checked, go to 46)

[] Uveitis (including other posterior uveitis and panuveitis syndromes) (If checked, go to 51)

[] Behcet's Disease (If checked, go to 55)

[] Pyoderma Gangrenosum (If checked, go to 59)

[] Sarcoidosis (If checked, go to 63)

[] Scleritis or Sterile Corneal Ulceration (If checked, go to 67)

[] Spondyloarthritis, other subtypes (for example, undifferentiated arthritis, non-radiographic axial spondyloarthritis, Reactive Arthritis [Reiter's disease], arthritis associated with inflammatory bowel disease [IBD]) (If checked, go to 70)

[] Enthesitis-Related Arthritis (If checked, go to 77)

[] Polymyalgia Rheumatica (PMR) (If checked, no further questions)

[] Other (If checked, no further questions)

12	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
13	Has the patient tried ONE conventional synthetic disease-modifying antirheumatic drug (DMARD) for at least 3 months or was intolerant to a conventional synthetic DMARD? [Note: Examples of conventional synthetic DMARDs include but not limited to methotrexate (oral or injectable), leflunomide, hydroxychloroquine, and sulfasalazine.] [If no, no further questions.]	Yes	No

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14	Is the requested medication prescribed by or in consultation with a rheumatologist? [If no, no further questions.]	Yes	No
15	Does the requested dose exceed FDA approved label dosing for the requested indication? [Note: Dosing: 40 mg every other week.] [No further questions.]	Yes	No
16	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
17	Is the requested medication prescribed by or in consultation with a rheumatologist? [If no, no further questions.]	Yes	No
18	Does the requested dose exceed FDA approved label dosing for the requested indication? [Note: Dosing: 40 mg every other week.] [No further questions.]	Yes	No
19	Is the patient greater than or equal to 6 years of age? [If no, no further questions.]	Yes	No
20	Has the patient tried or is currently taking corticosteroids? [Note: Examples of corticosteroids include but not limited to prednisone, methylprednisolone.] [If yes, skip to question 22.]	Yes	No
21	Are corticosteroids contraindicated in this patient? [Note: Examples of corticosteroids include but not limited to prednisone, methylprednisolone.] [If no, no further questions.]	Yes	No
22	Has the patient tried ONE other agent for Crohn's disease for at least 3 months? [Note: Examples of other agents for Crohn's disease include but not limited to azathioprine, 6-mercaptopurine, or methotrexate (MTX).] [If yes, skip to question 25.]	Yes	No
23	Does the patient have enterocutaneous (perianal or abdominal) or rectovaginal fistulas? [If yes, skip to question 25.]	Yes	No
24	Has the patient had ileocolonic resection (to reduce the chance of Crohn's disease recurrence)? [If no, no further questions.]	Yes	No
25	Is the requested medication prescribed by or in consultation with a	Yes	No

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	gastroenterologist? [If no, no further questions.]		
26	Does the requested dose exceed FDA approved label dosing for the requested indication? [Note: Dosing: 160 mg at week 0, 80 mg at week 2, and then 40 mg every other week at week 4 thereafter.] [No further questions.]	Yes	No
27	Is the patient greater than or equal to 2 years of age? [If no, no further questions.]	Yes	No
28	Has the patient tried ONE other agent for at least 3 months for the patient's condition? [Note: Examples of other agents for juvenile idiopathic arthritis (JIA) include but not limited to methotrexate (MTX), sulfasalazine, leflunomide, or a nonsteroidal anti-inflammatory drug (NSAID) (for example, ibuprofen, naproxen).] [If yes, skip to question 32.]	Yes	No
29	Will the patient be starting on the requested medication concurrently with methotrexate (MTX), sulfasalazine, or leflunomide? [If yes, skip to question 32.]	Yes	No
30	Does the patient have an absolute contraindication to methotrexate (MTX), sulfasalazine, or leflunomide? [Note: Examples of contraindications to MTX include pregnancy, breast feeding, alcoholic liver disease, immunodeficiency syndrome, and blood dyscrasias.] [If yes, skip to question 32.]	Yes	No
31	Does the patient have aggressive disease, as determined by the prescriber? [If no, no further questions.]	Yes	No
32	Is the requested medication prescribed by or in consultation with a rheumatologist? [If no, no further questions.]	Yes	No
33	Does the requested dose exceed FDA approved label dosing for the requested indication? [Note: Dosing: 40 mg every other week.] [No further questions.]	Yes	No
34	Is the patient greater than or equal to 12 years of age? [If no, no further questions.]	Yes	No
35	Has the patient tried at least ONE other therapy for at least 3 months? [Note: Examples include but not limited to intralesional or oral corticosteroids (such as triamcinolone, prednisone), systemic antibiotics (for example, clindamycin, dicloxacillin, erythromycin), or isotretinoin.]	Yes	No

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	[If no, no further questions.]		
36	Is the requested medication prescribed by or in consultation with a dermatologist? [If no, no further questions.]	Yes	No
37	Does the requested dose exceed FDA approved label dosing for the requested indication? [Note: Dosing: 160 mg at week 0, 80 mg at week 2, and then 40 mg every week at week 4 thereafter.] [No further questions.]	Yes	No
38	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
39	Has the patient tried at least TWO traditional systemic agents for psoriasis for at least 3 months or was intolerant to traditional systemic agents? [Note: Examples include but not limited to methotrexate (MTX), cyclosporine, acitretin (Soriatane generics).] [If no, no further questions.]	Yes	No
40	Is the requested medication prescribed by or in consultation with a dermatologist? [If no, no further questions.]	Yes	No
41	Does the requested dose exceed FDA approved label dosing for the requested indication? [Note: Dosing: 80 mg at week 0, and then 40 mg every other week starting at week 1 thereafter.] [No further questions.]	Yes	No
42	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
43	Has the patient tried ONE conventional synthetic disease-modifying antirheumatic drug (DMARD) for at least 3 months or was intolerant to conventional synthetic DMARD? [Note: Examples of conventional synthetic DMARDs include but not limited to methotrexate (oral or injectable), leflunomide, hydroxychloroquine and sulfasalazine.] [If no, no further questions.]	Yes	No
44	Is the requested medication prescribed by or in consultation with a rheumatologist or a dermatologist? [If no, no further questions.]	Yes	No
45	Does the requested dose exceed FDA approved label dosing for the requested indication? [Note: Dosing: 40 mg every other week.] [No further questions.]	Yes	No

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46	Is the patient greater than or equal to 5 years of age? [If no, no further questions.]	Yes	No
47	Has the patient had a trial of ONE systemic agent or a corticosteroid enema, or Rowasa (mesalamine) enema for at least 3 months or was intolerant to systemic/enema agents? [Note: Examples include but not limited to 6-mercaptopurine, azathioprine, cyclosporine, tacrolimus, or a corticosteroid. Examples of corticosteroid enemas include but not limited to hydrocortisone enema (Cortenema, generics).] [If no, no further questions.]	Yes	No
48	Does the patient have pouchitis? [If no, no further questions.]	Yes	No
49	Is the requested medication prescribed by or in consultation with a gastroenterologist? [If no, no further questions.]	Yes	No
50	Does the requested dose exceed FDA approved label dosing for the requested indication? [Note: Dosing: 160 mg at week 0, 80 mg at week 2, and then 40 mg every other week at week 4 thereafter.] [No further questions.]	Yes	No
51	Is the patient greater than or equal to 2 years of age? [If no, no further questions.]	Yes	No
52	Has the patient tried ONE of the following therapies: A) Periocular corticosteroids, B) Intraocular corticosteroids, C) Systemic corticosteroids for at least 3 months for the patient's condition or was intolerant to the therapy? [Note: Examples of corticosteroids include but not limited to prednisolone, triamcinolone, betamethasone, methylprednisolone, and prednisone.] [If no, no further questions.]	Yes	No
53	Is the requested medication prescribed by or in consultation with an ophthalmologist? [If no, no further questions.]	Yes	No
54	Does the requested dose exceed FDA approved label dosing for the requested indication? [Note: Dosing: 80 mg at week 0, and then 40 mg every other week starting at week 1 thereafter.] [No further questions.]	Yes	No
55	Has the patient tried at least ONE conventional therapy for at least 3 months? [Note: Examples include but not limited to systemic corticosteroids (for example, methylprednisolone), immunosuppressants (for example, azathioprine,	Yes	No

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	methotrexate [MTX], mycophenolate mofetil, cyclosporine, tacrolimus, Leukeran [chlorambucil], cyclophosphamide), interferon alfa.] [If yes, skip to question 57.]		
56	Does the patient have ophthalmic manifestations of Behcet's disease? [If no, no further questions.]	Yes	No
57	Is the requested medication prescribed by or in consultation with a rheumatologist, dermatologist, ophthalmologist, gastroenterologist, or neurologist? [If no, no further questions.]	Yes	No
58	Does the requested dose exceed FDA approved label dosing for the requested indication? [Note: Dosing: 80 mg at week 0, and then 40 mg every other week starting at week 1 thereafter.] [No further questions.]	Yes	No
59	Has the patient tried ONE systemic corticosteroid for at least 3 months? [Note: An example is prednisone.] [If yes, skip to question 61.]	Yes	No
60	Has the patient tried ONE other immunosuppressant for at least 2 months or was intolerant to one of these agents? [Note: Examples include but not limited to mycophenolate mofetil and cyclosporine.] [If no, no further questions.]	Yes	No
61	Is the requested medication prescribed by or in consultation with a dermatologist? [If no, no further questions.]	Yes	No
62	Does the requested dose exceed FDA approved label dosing for the requested indication? [Note: Dosing: 40 mg every other week.] [No further questions.]	Yes	No
63	Has the patient tried at least ONE corticosteroid for at least 3 months for this condition? [Note: An example is prednisone.] [If no, no further questions.]	Yes	No
64	Has the patient tried at least ONE immunosuppressive agent for at least 3 months? [Note: Examples include but not limited to methotrexate (MTX), leflunomide, azathioprine, mycophenolate mofetil, cyclosporine, Leukeran (chlorambucil), cyclophosphamide, Thalomid (thalidomide capsules), an infliximab product, or chloroquine.] [If no, no further questions.]	Yes	No

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65	Is the requested medication prescribed by or in consultation with a pulmonologist, ophthalmologist, or dermatologist? [If no, no further questions.]	Yes	No
66	Does the requested dose exceed FDA approved label dosing for the requested indication? [Note: Dosing: 40 mg every other week.] [No further questions.]	Yes	No
67	Has the patient tried ONE other therapy for at least 3 months for the patient's condition? [Note: Examples include but not limited to oral nonsteroidal anti-inflammatory drugs (NSAIDs) such as indomethacin, naproxen, or ibuprofen; oral, topical (ophthalmic) or IV corticosteroids (such as prednisone, prednisolone, methylprednisolone); methotrexate (MTX); cyclosporine; or other immunosuppressants.] [If no, no further questions.]	Yes	No
68	Is the requested medication prescribed by or in consultation with an ophthalmologist? [If no, no further questions.]	Yes	No
69	Does the requested dose exceed FDA approved label dosing for the requested indication? [Note: Dosing: Maximum of 40 mg every week.] [No further questions.]	Yes	No
70	Does the patient have arthritis primarily in the knees, ankles, elbows, wrists, hands, and/or feet? [If no, skip to question 72.]	Yes	No
71	Has the patient tried at least ONE conventional synthetic disease-modifying antirheumatic drug (DMARD) for at least 3 months? [Note: Examples include but not limited to methotrexate (MTX), leflunomide, sulfasalazine.] [If yes, skip to question 75.]	Yes	No
72	Does the patient have axial spondyloarthritis? [If no, no further questions.]	Yes	No
73	Does the patient have objective signs of inflammation, defined as: C-reactive protein (CRP) elevated beyond the upper limit of normal for the reporting laboratory? [If yes, skip to question 75.]	Yes	No
74	Does the patient have objective signs of inflammation, defined as: sacroiliitis reported on magnetic resonance imaging (MRI)? [If no, no further questions.]	Yes	No

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75	Is the requested medication prescribed by or in consultation with a rheumatologist? [If no, no further questions.]	Yes	No
76	Does the requested dose exceed FDA approved label dosing for the requested indication? [Note: Dosing: 40 mg every other week.] [No further questions.]	Yes	No
77	Is the patient greater than or equal to 2 years of age? [If no, no further questions.]	Yes	No
78	Has the patient tried at least ONE systemic agent for at least 3 months? [Note: Examples of systemic agents include but not limited to NSAIDs such as ibuprofen and naproxen.] [If yes, skip to question 80.]	Yes	No
79	Has documentation been submitted to confirm that the patient has intolerance to at least TWO systemic agents? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
80	Is the requested medication prescribed by or in consultation with a rheumatologist? [If no, no further questions.]	Yes	No
81	Does the requested dose exceed FDA approved label dosing for the requested indication? [Note: Dosing: 40 mg every other week.]	Yes	No

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

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

If you have any questions, call: 1-888-258-8250

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FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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