



# Humira (adalimumab) Prior Authorization of Benefits Form

**CONTAINS CONFIDENTIAL PATIENT INFORMATION**

Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-512-9004

Provider Help Desk 1-800-454-3730

**1. Patient information**

**2. Physician information**

Patient name: _____	Prescribing physician: _____
Patient ID #: _____	Physician address: _____
Patient DOB: _____	Physician phone #: _____
Date of Rx: _____	Physician fax #: _____
Patient phone #: _____	Physician specialty: _____
Patient email address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician email address: _____

**3. Medication**

**4. Strength**

**5. Directions**

**6. Quantity per 30 days**

Humira (adalimumab)	_____	_____	Specify: _____
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**7. Diagnosis:** \_\_\_\_\_

**8. Approval criteria:** (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

**Required for All Requests:**

- Yes  No Patient has been screened for hepatitis B and C [PLEASE NOTE: patients with active hepatitis B will not be considered for coverage]
- Yes  No Patient has been treated for solid malignancies, non-melanoma skin cancer, or lymphoproliferative malignancy within the last 5 years of starting or resuming treatment with a biological agent [PLEASE NOTE: Biological agents include: Abatacept (Orencia); Adalimumab (Humira); Anakinra (Kineret); Certolizumab Pegol (Cimzia); Etanercept (Enbrel); Infliximab (Remicade); Golimumab (Simponi); Tocilizumab (Actemra); Ustekinumab (Stelara); Secukinumab (Cosentyx)]
- Yes  No Patient has a diagnosis of congestive heart failure (CHF) that is New York Heart Association (NYHA) class III or IV and with an ejection fraction of 50% or less
- Yes  No Patient has been screened for latent TB infection [PLEASE NOTE: patients with latent TB will only be considered after one month of TB treatment and patients with active TB will only be considered upon completion of TB Treatment]
- Yes  No The request medication will be given concurrently with live vaccines.

**Required for All Requests: (Continued from page 1)**

- Yes    No   Patient had a previous trial and therapeutic failure with TWO preferred biological medications [Please Note the PREFERRED biologic medications are: Cosentyx, Enbrel, and Humira.]  
**\*DOCUMENTATION must be submitted which includes the following information:** the patient has had previous trials and therapy failures with two preferred biological agents. Documentation may include, but is not limited to, chart notes, prescription claims records, prescription receipts, and laboratory data.

**Plaque Psoriasis:**

- Yes    No   Patient has a diagnosis of plaque psoriasis
- Yes    No   Patient had an inadequate response to phototherapy, systemic retinoids (oral isotretinoin), methotrexate, or cyclosporine  
**\*DOCUMENTATION must be submitted which includes the following information:** the patient had an inadequate response to phototherapy, systemic retinoids (oral isotretinoin), methotrexate, or cyclosporine. Documentation may include, but is not limited to, chart notes, prescription claims records, prescription receipts, and laboratory data.

**Ankylosing Spondylitis:**

- Yes    No   Patient has a diagnosis of ankylosing spondylitis
- Yes    No   Patient had an inadequate response to at least TWO preferred non-steroidal anti-inflammatories (NSAIDs) at maximum therapeutic doses (trials should be at least three months in duration)
- Yes    No   Patient has adverse responses or contraindications to NSAID use  
PLEASE NOTE: The Preferred NSAIDs are: diclofenac potassium, diclofenac sodium, etodolac tab 400 mg, etodolac tab 500 mg, flurbiprofen, ibuprofen Susp 100 MG/5ML, Ibuprofen tab 200 MG, ibuprofen tab 400 mg, ibuprofen tab 600 mg, ibuprofen tab 800 mg, indomethacin, ketoprofen, NAPROSYN SUSP, naproxen, naproxen sodium tab 550 mg, sulindac.  
**\*DOCUMENTATION must be submitted which includes the following information:** that there is clinical evidence that the use of the preferred non-steroidal anti-inflammatories (NSAIDs) would be medically contraindicated for this patient or that the patient had trials and inadequate responses with these agents. Documentation may include, but is not limited to, chart notes, prescription claims records, prescription receipts, and laboratory data.
- Yes    No   Patient has symptoms of peripheral arthritis
- Yes    No   Patient failed a 30-day treatment trial with at least one conventional disease modifying antirheumatic drug (DMARD) (DMARDs include sulfasalazine and methotrexate)
- Yes    No   Patient has a documented\* adverse response or contraindication to DMARD use  
PLEASE NOTE: DMARDs include sulfasalazine and methotrexate  
**\*DOCUMENTATION must be submitted which includes the following information:** that there is clinical evidence that the use of the DMARD would be medically contraindicated for this patient. Documentation may include, but is not limited to, chart notes, prescription claims records, prescription receipts, and laboratory data.

**Rheumatoid Arthritis (RA):**

- Yes    No   Patient has a diagnosis of rheumatoid arthritis (RA)
  - Yes    No   Patient had a trial, and inadequate response to, TWO preferred disease modifying anti-rheumatic drugs (DMARDs) used concurrently. PLEASE NOTE: The combination must include methotrexate plus another preferred oral DMARD (hydroxychloroquine, sulfasalazine, or leflunomide)
  - Yes    No   Patient had a clinical evidence that the use of methotrexate and/or the preferred medications would be medically contraindicated for this patient. PLEASE NOTE: The preferred DMARDs are hydroxychloroquine, sulfasalazine, and leflunomide
  - Yes    No   Patient had an unsuccessful methotrexate trial
  - Yes    No   There evidence of severe disease documented by radiographic erosions
- \*DOCUMENTATION must be submitted which includes the following information:** that there is a clinical evidence that the use of the preferred oral DMARD, methotrexate would be medically contraindicated for this patient, AND if there is a contraindication to methotrexate then also the clinical reason this patient would not be able to use leflunomide or sulfasalazine instead. Documentation may include but is not limited to, chart notes, prescriptions claims records, prescription receipts, and laboratory data.

**Moderate to Severe Psoriatic Arthritis:**

- Yes    No   Patient has a diagnosis of moderate to severe psoriatic arthritis
  - Yes    No   Patient had a trial and inadequate response to the preferred oral DMARD, methotrexate [PLEASE NOTE: The preferred DMARDs are hydroxychloroquine, sulfasalazine, leflunomide, and minocycline].
  - Yes    No   Patient have a contraindication to the use of methotrexate
  - Yes    No   Patient had a trial of leflunomide or sulfasalazine
- \*DOCUMENTATION must be submitted which includes the following information:** that there is a clinical evidence that the use of the preferred oral DMARD, methotrexate would be medically contraindicated for this patient, AND if there is a contraindication to methotrexate then also the clinical reason this patient would not be able to use leflunomide or sulfasalazine instead. Documentation may include but is not limited to, chart notes, prescriptions claims records, prescription receipts, and laboratory data.

**Moderate to Severe Juvenile Idiopathic Arthritis:**

- Yes    No   Patient has a diagnosis of moderate to severe juvenile idiopathic arthritis
  - Yes    No   Patient has had a trial, and inadequate response to, intraarticular glucocorticoid injections and the preferred oral DMARD, methotrexate PLEASE NOTE: The preferred DMARDs are hydroxychloroquine, sulfasalazine, leflunomide, and minocycline.
  - Yes    No   Patient have a contraindication to the use of methotrexate
  - Yes    No   Patient had a trial of leflunomide or sulfasalazine
- \*DOCUMENTATION must be submitted which includes the following information:** that there is a clinical evidence that the use of the preferred oral DMARD, methotrexate would be medically contraindicated for this patient, AND if there is a contraindication to methotrexate then also the clinical reason this patient would not be able to use leflunomide or sulfasalazine instead. Documentation may include but is not limited to, chart notes, prescriptions claims records, prescription receipts, and laboratory data.

**Crohn's Disease:**

- Yes    No   Patient has a diagnosis of Crohn's Disease
  - Yes    No   Patient has a trial and inadequate response to TWO preferred conventional therapy including aminosalicylates (mesalamine, sulfasalazine), azathioprine/6-mercaptopurine, AND/OR methotrexate
- \*DOCUMENTATION must be submitted which includes the following information:** that there is clinical evidence that the use of the preferred conventional therapy including aminosalicylates (mesalamine, sulfasalazine), azathioprine/6-mercaptopurine, AND/OR methotrexate would be medically contraindicated for this patient. Documentation may include, but is not limited to, chart notes, prescription claims records, prescription receipts, and laboratory data.

**Ulcerative Colitis (moderate to severe):**

- Yes    No   Patient has a diagnosis of ulcerative colitis (moderate to severe)
- Yes    No   Patient has a trial and inadequate response to TWO preferred conventional therapies including aminosalicylates (mesalamine, sulfasalazine), and azathioprine/6-mercaptopurine
- \*DOCUMENTATION must be submitted which includes the following information:** that there is clinical evidence that the use of the preferred conventional therapy including aminosalicylates (mesalamine, sulfasalazine), and azathioprine/6-mercaptopurine would be medically contraindicated for this patient. Documentation may include, but is not limited to, chart notes, prescription claims records, prescription receipts, and laboratory data.

**Hidradenitis Suppurativa (HS):**

*Requests for initial therapy:*

- Yes    No   Patient has a diagnosis of moderate to severe HS with Hurley Stage II or III disease
- Yes    No   Patient has at least three (3) abscesses or inflammatory nodules
- Yes    No   Patient has documentation of adequate trials and therapy failures with the following (please indicate):
  - Yes    No   Daily treatment with topical clindamycin
  - Yes    No   Oral clindamycin plus rifampin
  - Yes    No   Maintenance therapy with tetracyclines (doxycycline or minocycline)
- Yes    No   Documented\* evidence has been provided that use of these agents would be medically contraindicated
- Yes    No   Patient is 18 years of age or older

*Requests for continued therapy:*

- Yes    No   Documentation\* of clinical response to therapy is provided (clinical response is defined as at least a 50% reduction in total abscess and inflammatory nodule count with no increase in abscess count and no increase in draining fistula count from initiation of therapy)

**9. Physician signature**

_____	_____
Prescriber or authorized signature	Date
<p><i>Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient.</i></p> <p>Note: Payment is subject to member eligibility. Authorization does not guarantee payment.</p>	
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