

Humira and Biosimilar Agents Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-474-3341.

1. Patient information
2. Physician information

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

3. Medication
4. Strength
5. Directions
6. Quantity per 30 days

Humira			Specify:
--------	--	--	----------

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.)

<input type="checkbox"/>	<input type="checkbox"/>	The requested medication is being provided and billed at the physician's office?
<input type="checkbox"/>	<input type="checkbox"/>	Does the member have a diagnosis of rheumatoid arthritis (RA), ankylosing spondylitis (AS), psoriatic arthritis (PsA), ulcerative colitis (UC), uveitis (UV) and/or plaque psoriasis (Ps) in the last 730 days?
<input type="checkbox"/>	<input type="checkbox"/>	Does the member have a diagnosis of Crohn's disease in the last 730 days?
<input type="checkbox"/>	<input type="checkbox"/>	Does the member have a diagnosis of juvenile idiopathic arthritis (PJIA) in the last 730 days?
<input type="checkbox"/>	<input type="checkbox"/>	Does the member have a diagnosis of hidradenitis suppurativa (HS) in the last 730 days?
<input type="checkbox"/>	<input type="checkbox"/>	Does the member have a history of heart failure in the last 365 days?
<input type="checkbox"/>	<input type="checkbox"/>	Does the member have a history of demyelinating disease (multiple sclerosis, optic neuritis, and/or Guillain-Barre syndrome) in the last 365 days?
<input type="checkbox"/>	<input type="checkbox"/>	Does the member have a history of hematologic abnormalities in the last 180 days?
<input type="checkbox"/>	<input type="checkbox"/>	Does the member have a serious active infection (including Hepatitis B virus and/or tuberculosis) in the last 180 days?

For the *Texas Medicaid Preferred Drug List*, please refer to the Texas Medicaid Vendor Drug Program website at <http://www.txvendordrug.com/formulary/formulary-search.asp>.

9. Physician signature

Prescriber or authorized signature

Date

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. Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

The document(s) accompanying this transmission may contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.