

Pharmacy Prior Authorization Form

Last Reviewed: Mar. 09

For Prior Authorization please fax to: (877)974-4411 toll free, or (616)942-8206

This form applies to: Commercial Plan Medicaid Plan Medicare Plan

Humira[®] (adalimumab) Urgent Non-urgent

Member Name:	Member #:
DOB:	Gender:
Provider Name:	Provider Phone:
Provider Office Address:	
Provider Office Contact Name:	Provider Fax:
Provider Signature:	Provider NPI:
Date:	Member's PCP:

Product:

- Humira Pen Carton – 40 mg
- Humira Pen- Crohn's Disease Starter Pack
- Humira Prefilled Syringe Carton – 40 mg
- Humira Pediatric Prefilled Syringe Carton – 20 mg

Dose: _____ Start date: _____

Prescriber is a rheumatologist:

- Yes
- No

Priority Health Precertification Requirements:

Authorization of Humira requires:

- One of the following diagnoses:
 1. Rheumatoid arthritis
 - Documented therapeutic trial of at least one DMARD
 2. Juvenile rheumatoid arthritis
 - Documented therapeutic trial of at least one DMARD
 3. Psoriatic arthritis
 - Documented therapeutic trial of at least one DMARD
 4. Ankylosing spondylitis
 - Presence of active disease of at least 4 weeks
 - BASDAI score of at least 4
 - Documented therapeutic trial and failure of at least two NSAIDs during a single 3-month period
 - Documented therapeutic trial of intra-articular steroids
 - Documented therapeutic trial of sulfasalazine
 5. Moderate to severe plaque psoriasis
 - Involvement of greater than 10% of body surface area (unless hands, feet, head, neck, or genitalia are involved)
 - Documented therapeutic trial of one or more topical agents
 - Documented therapeutic trial of phototherapy
 - Documented therapeutic trial of one or more systemic treatments
 6. Crohn's Disease
 - Documented therapeutic trial of at least two of the following formulary alternatives: corticosteroids, sulfasalazine, osalazine, and mesalamine
- Negative TB test (must be done yearly)
- Patient must **not** have moderate to severe heart failure

Continuation of Humira therapy requires:

- Patient must be compliant taking the medication as prescribed
- Patient must be tolerating the medication
- Patient must not be experiencing any severe adverse reactions while taking the medication
- Patient must be responding positively to the medication
- Patient must have a negative TB test within the past 12 months

Diagnosis:

- Rheumatoid Arthritis
- Juvenile Rheumatoid Arthritis
- Psoriatic Arthritis
- Ankylosing Spondylitis
- Plaque psoriasis
- Crohn's Disease
- Other: _____ Please provide rationale for use: _____

Results of annual (within the past 12 months) TB test:

- Positive - Rationale for use: _____
- Negative
- Test not done – Rationale for use: _____

Patient has moderate to severe heart failure:

- Yes – Rationale for use: _____
- No

New request or continuation of therapy:

- New (see section 1)
- Continuation (see section 2)

Section 1 – New requests:
Rheumatoid Arthritis, Juvenile Rheumatoid Arthritis, or Psoriatic Arthritis

Patient has had a therapeutic trial of at least one of the following DMARDs:

- Yes
 - No – Rationale for use: _____
- | | Dose | Dates | Outcome |
|---|-------|-------|---------|
| <input type="checkbox"/> azathioprine | _____ | _____ | _____ |
| <input type="checkbox"/> Cyclosporine | _____ | _____ | _____ |
| <input type="checkbox"/> d-penicillamine | _____ | _____ | _____ |
| <input type="checkbox"/> gold sodium thiomalate | _____ | _____ | _____ |
| <input type="checkbox"/> auranofin | _____ | _____ | _____ |
| <input type="checkbox"/> aurothioglucose | _____ | _____ | _____ |
| <input type="checkbox"/> hydroxychloroquine | _____ | _____ | _____ |
| <input type="checkbox"/> leflunomide | _____ | _____ | _____ |
| <input type="checkbox"/> methotrexate | _____ | _____ | _____ |
| <input type="checkbox"/> sulfasalazine | _____ | _____ | _____ |

Ankylosing Spondylitis

Patient has shown presence of active disease for at least 4 weeks:

 Yes No – Rationale for use: _____

Patient has had a sustained BASDAI score of at least 4: BASDAI score: _____

 Yes No – Rationale for use: _____

Patient has had a therapeutic trial of at least two NSAIDs during a single 3-month period:

 Yes No – Rationale for use: _____

NSAID: _____ Dose: _____ Trial dates: _____

NSAID: _____ Dose: _____ Trial dates: _____

Patient has had a therapeutic trial of intra-articular steroids and sulfasalazine:

 Yes No – Rationale for use: _____

Drug: _____ Dose: _____ Trial dates: _____

Drug: _____ Dose: _____ Trial dates: _____

Plaque Psoriasis

Plaque affects > 10% of the patient's body surface area:

 Yes No

Plaque psoriasis affects the hand, feet, head, neck, or genitalia:

 Yes No

Patient has had a documented trial and clinical failure of one or more topical agents:

 Yes No – Rationale for use: _____

Drug: _____ Dose: _____ Trial dates: _____

Drug: _____ Dose: _____ Trial dates: _____

Patient has had a documented trial and clinical failure with phototherapy (UVA, UVB):

 Yes No – Rationale for use: _____

Type of therapy: _____ Trial dates: _____

Patient has had a documented trial and clinical failure of one or more systemic treatments (azathioprine, Neoral, methotrexate, cyclosporine, Soriatane):

 Yes No – Rationale for use: _____

Drug: _____ Dose: _____ Trial dates: _____

Drug: _____ Dose: _____ Trial dates: _____

Patient has a contraindication to systemic treatments:

- Yes
- No

List the contraindication: _____

Crohn's Disease

Patient has had a documented trial and clinical failure of at least **two** of the following:

- Yes

	Dose	Dates	Outcome
<input type="checkbox"/> corticosteroid	_____	_____	_____
<input type="checkbox"/> sulfasalazine	_____	_____	_____
<input type="checkbox"/> olsalazine	_____	_____	_____
<input type="checkbox"/> mesalamine	_____	_____	_____

- No – Rationale for use: _____
-

Section 2 – Requests for continuation of therapy:

- The patient is compliant in taking the medication as scheduled
- The patient tolerated the medication
- The patient did not experience any severe adverse reactions while taking the medication
- The patient has responded to treatment, as determined by the prescribing physician
- The patient has had a negative TB test result within the past 12 months-
Date of test: _____

Note: Approval, when granted, will be for a 30 day supply per fill at the dose and duration outlined below in table 1.

TABLE 1. Dose and Duration of Authorization

Indication	Initial Authorization	Continuation Authorization
Adult rheumatoid arthritis	<ul style="list-style-type: none"> Approved for 3 months Approved dose is 40mg SQ every other week 	<ul style="list-style-type: none"> Approved for an additional 12 months if the patient has responded, as determined by the prescribing physician Approved dose is 40mg SQ every other week
Juvenile idiopathic arthritis	<ul style="list-style-type: none"> Approved for 3 months Approved dose is 20mg SQ every other week (for weight 15kg - <30kg) or 40mg SQ every other week (for weight ≥ 30 kg) 	<ul style="list-style-type: none"> Approved for an additional 12 months if the patient has responded, as determined by the prescribing physician Approved dose is 20mg SQ every other week (for weight 15kg - <30kg) or 40mg SQ every other week (for weight ≥ 30 kg)
Psoriatic arthritis	<ul style="list-style-type: none"> Approved for 3 months Approved dose is 40mg SQ every other week 	<ul style="list-style-type: none"> Approved for an additional 12 months if the patient has responded, as determined by the prescribing physician Approved dose is 40mg SQ every other week
Ankylosing spondylitis	<ul style="list-style-type: none"> Approved for 3 months Approved dose is 40mg SQ every other week 	<ul style="list-style-type: none"> Approved for an additional 12 months if the patient has responded, as determined by the prescribing physician Approved dose is 40mg SQ every other week
Crohn's disease	<ul style="list-style-type: none"> Approved for 3 months Approved dose is 160 mg initially at day 1 (given as four 40 mg injections in 1 day or as two 40 mg injections per day for 2 consecutive days), followed by 80 mg 2 weeks later (day 15). Two weeks later (day 29), begin a maintenance dosage of 40 mg every other week. 	<ul style="list-style-type: none"> Approve for an additional 12 months of therapy if the patient has responded, as determined by the prescribing physician Approved dose is 40mg SQ every other week
Plaque psoriasis	<ul style="list-style-type: none"> Approved for 3 months Approved dose is 80 mg initially, followed by 40 mg given every other week starting 1 week after the initial dose 	<ul style="list-style-type: none"> Approved for an additional 3 months if the patient has responded, as determined by the prescribing physician Approved dose is 40mg SQ every other week If Humira proves to be effective for the patient, then they may receive additional therapy courses beyond 6 months upon disease recurrence

***** All fields must be complete and legible for Prior Authorization Review*****

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YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX