

Pharmacy

PRIOR AUTHORIZATION FORM

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 (life threatening)

Non-Urgent (standard review)

A claim involving "urgent care" applies when the standard review time will seriously jeopardize the life or health of the member, or subject the member to severe pain that cannot be managed without the care or treatment requested in the subject of this request. **Priority Health averages between 1 and 3 business days for our standard review response time.**

Member Information

Member Name:	Member No.:
DOB:	Gender:
Member's PCP:	

Provider Information

Provider Name:	
Office Contact Name:	Provider Phone:
Provider NPI:	Provider Fax:
Provider Address:	

Provider Signature

Date

Prescriber is a rheumatologist

PRODUCT INFORMATION

- Humira[®] 40mg/0.8mL Crohns Disease Starter Package
- Humira[®] 40mg/0.8mL Pre-filled Pen Kit
- Humira[®] 40mg/0.8mL Pre-filled Syringe Kit
- Humira[®] 40mg/0.8mL Psoriasis Starter Package
- Humira[®] 20mg/0.4mL Pediatric Pre-filled Syringe Kit

Dose: _____

Start Date: _____

(for new requests)

THIS REQUEST IS FOR:

New therapy – complete SECTION A

Continuation – complete SECTION B

NOTE: Humira[®], when approved, will be limited to a 30 day-supply for each fill at the dose and duration outlined in Table 1.

PRECERTIFICATION REQUIREMENTS

PRIORITY HEALTH PRECERTIFICATION REQUIREMENTS

Authorization for Humira[®] (adalimumab) requires the following information to certify:

Patient must have met the following requirements:

1. **Patient must have one of the following diagnoses and completed step therapy:**
 - Rheumatoid Arthritis with documented therapeutic trial of at least one DMARD
 - Juvenile Idiopathic Arthritis with documented therapeutic trial of at least one DMARD
 - Psoriatic Arthritis with documented therapeutic trial of at least one DMARD
 - Ankylosing Spondylitis *with*:
 - presence of active disease for at least 4 weeks
 - a BASDAI score of at least 4
 - a documented therapeutic trial and clinical failure of at least two NSAIDs during a 3-month time period
 - a documented therapeutic trial of intra-articular steroids
 - a documented therapeutic trial of sulfasalazine
 - Moderate to Severe Plaque Psoriasis *with*:
 - involvement of greater than 10% of body surface area (unless hands, feet, head, neck, or genitalia are involved)
 - a documented therapeutic trial of at least one topical agent
 - a documented therapeutic trial of phototherapy
 - a documented therapeutic trial of at least one systemic treatment
 - Crohn's Disease *with*:
 - a documented therapeutic trial of at least two of the following formulary alternatives: corticosteroids, sulfasalazine, olsalazine, and mesalamine
2. **Patient must have a negative TB test result yearly**
3. **Patient must not have moderate to severe heart failure**

For continuation, patient must have met the following requirements:

- 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 had a negative TB test result in the previous 12 months

SECTION A – NEW THERAPY

PRIORITY HEALTH PRECERTIFICATION DOCUMENTATION

Authorization for Humira[®] (adalimumab) requires the following information to certify:

A. Patient has one of the following diagnoses:

1. Rheumatoid Arthritis (*with a trial of at least one DMARD*)
- Juvenile Idiopathic Arthritis (*with a trial of at least one DMARD*)
- Psoriatic Arthritis (*with a trial of at least one DMARD*)

For any of the above, which of the following DMARDs were used in this patient?

- | | | | |
|---|-------------|--------------|----------------|
| <input type="checkbox"/> azathioprine | Dose: _____ | Dates: _____ | Outcome: _____ |
| <input type="checkbox"/> cyclosporine | Dose: _____ | Dates: _____ | Outcome: _____ |
| <input type="checkbox"/> d-penicillamine | Dose: _____ | Dates: _____ | Outcome: _____ |
| <input type="checkbox"/> gold sodium thiomalate | Dose: _____ | Dates: _____ | Outcome: _____ |
| <input type="checkbox"/> auranofin | Dose: _____ | Dates: _____ | Outcome: _____ |
| <input type="checkbox"/> aurothioglucose | Dose: _____ | Dates: _____ | Outcome: _____ |
| <input type="checkbox"/> hydroxychloroquine | Dose: _____ | Dates: _____ | Outcome: _____ |
| <input type="checkbox"/> leflunomide | Dose: _____ | Dates: _____ | Outcome: _____ |
| <input type="checkbox"/> methotrexate | Dose: _____ | Dates: _____ | Outcome: _____ |
| <input type="checkbox"/> sulfasalazine | Dose: _____ | Dates: _____ | Outcome: _____ |
| <input type="checkbox"/> None of the above – Rationale for use: _____ | | | |

2. Ankylosing Spondylitis
- Patient has shown presence of active disease for at least 4 weeks
 - Patient has a sustained BASDAI score of at least 4 (BASDAI score: _____)
 - Patient had a therapeutic trial of at least two NSAIDs during a single 3-month time period
 - Drug: _____ Dose: _____ Dates: _____
 - Drug: _____ Dose: _____ Dates: _____
 - Patient had a therapeutic trial of intra-articular steroids and sulfasalazine
 - Drug: _____ Dose: _____ Dates: _____
 - Drug: _____ Dose: _____ Dates: _____
 - Not all of the above criteria met. Rationale for use: _____
-

3. Plaque Psoriasis
- Plaque affects 10% or more of the patient's body surface area, or
 - Plaque psoriasis affects the hands, feet, head, neck, or genitalia, and
 - Patient had a therapeutic trial and clinical failure with at least one topical agent
 - Patient had a therapeutic trial with phototherapy (UVA, UVB, or methoxsalen plus UVA)
 - Patient had a therapeutic trial with at least one of the following systemic treatments:
 - azathioprine Dose: _____ Dates: _____
 - Neoral Dose: _____ Dates: _____
 - Methotrexate Dose: _____ Dates: _____
 - cyclosporine Dose: _____ Dates: _____
 - Soriatane Dose: _____ Dates: _____
 - Other: _____ Dose: _____ Dates: _____
 - Systemic treatments contraindicated: Reason: _____
 - Not all of the above criteria met. Rationale for use: _____
-

4. Crohn's Disease
- Patient had a therapeutic trial and clinical failure with at least **two** of the following:
- corticosteroid Dose: _____ Dates: _____ Outcome: _____
 - sulfasalazine Dose: _____ Dates: _____ Outcome: _____
 - olsalazine Dose: _____ Dates: _____ Outcome: _____
 - mesalamine Dose: _____ Dates: _____ Outcome: _____

5. Patient does not have one of the above diagnoses. The diagnosis is: _____
- Rationale for use: _____
-

B. Patient had a negative TB test (must be tested yearly)?

- Yes – Date of test: _____
- No – Rationale: _____

C. Does this patient have moderate to severe heart failure?

- No
- Yes - Rationale for use: _____

SECTION B – CONTINUATION THERAPY

PRIORITY HEALTH PRECERTIFICATION DOCUMENTATION

Authorization for continuation of Humira[®] (adalimumab) requires the following information to certify:

For continuing authorization of Humira[®], all of the following criteria must be met:

1. What is the patient's diagnosis (must have one of the following diagnoses to qualify for continuation of therapy, unless previously authorized by Priority Health)?
 - Rheumatoid Arthritis
 - Juvenile Rheumatoid Arthritis
 - Psoriatic Arthritis
 - Ankylosing Spondylitis
 - Plaque Psoriasis
 - Crohn's Disease

2. **Select which of the following apply** (all must be met 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 had a negative TB test result in the previous 12 months. Date of test: _____

TABLE 1. DOSE AND DURATION OF AUTHORIZATION

Indication	Initial Authorization	Continuing Authorization
<ul style="list-style-type: none"> ❖ Adult rheumatoid arthritis ❖ Ankylosing spondylitis ❖ Psoriatic arthritis 	<ul style="list-style-type: none"> • Approved for 3 months • Approved dose is 40mg subcutaneously every other week 	<ul style="list-style-type: none"> • Approved for an additional 12 months if patient has responded to treatment, as determined by the prescribing physician • Approved dose is 40 mg subcutaneously every other week
<ul style="list-style-type: none"> ❖ Juvenile idiopathic arthritis 	<ul style="list-style-type: none"> • Approved for 3 months • Approved dose is 20mg subcutaneously every other week (15-29.9kg) or 40mg subcutaneously every other week (≥ 30kg) 	<ul style="list-style-type: none"> • Approved for an additional 12 months if patient has responded to treatment, as determined by the prescribing physician • Approved dose is 20mg subcutaneously every other week (15-29.9kg) or 40mg subcutaneously every other week (≥ 30kg)
<ul style="list-style-type: none"> ❖ Crohn's disease 	<ul style="list-style-type: none"> • Approved for 3 months • Approved dose is 160mg day 1 (given as four 40mg subcutaneous injections over 1 or 2 days), 80mg day 15, then 40mg every other week beginning day 29 	<ul style="list-style-type: none"> • Approved for an additional 12 months if patient has responded to treatment, as determined by the prescribing physician • Approved dose is 40 mg subcutaneously every other week
<ul style="list-style-type: none"> ❖ Plaque Psoriasis 	<ul style="list-style-type: none"> • Approved for 3 months • Approved dose is 80mg subcutaneously day 1, then 40mg subcutaneously every other week beginning on day 8 	<ul style="list-style-type: none"> • Approved for an additional 12 months if patient has responded to treatment, as determined by the prescribing physician • Approved dose is 40 mg subcutaneously every other week

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

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YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX