

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 then 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 _____

 Prescriber is a rheumatologist

Date _____

THIS REQUEST IS FOR: New therapy – complete SECTION A Continuation – complete SECTION B

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)

PRIORITY HEALTH PRECERTIFICATION REQUIRMENTS

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

1. **Patient must have one of the following diagnoses and meet any required criteria:**
 - Rheumatoid Arthritis
 - Juvenile Idiopathic Arthritis
 - Psoriatic Arthritis
 - Ankylosing Spondylitis *with* presence of active disease for at least 4 weeks and a BASDAI score of at least 4
 - Moderate to Severe Plaque Psoriasis *with* involvement of greater than 10% of body surface area (unless hands, feet, head, neck, or genitalia are involved)
 - Crohn's Disease
2. **Patient must have a negative TB test result yearly**
3. **Patient must not have moderate to severe heart failure**

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
2. Juvenile Idiopathic Arthritis
3. Psoriatic Arthritis
4. 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: _____)
 - Not all of the above criteria met. Rationale for use: _____
5. Plaque Psoriasis (moderate to severe)
 - Plaque affects 10% or more of the patient's body surface area, or
 - Plaque psoriasis affects the hands, feet, head, neck, or genitalia
 - Not all of the above criteria met. Rationale for use: _____
6. Crohn's Disease
7. Other: _____
Rationale for use: _____

Note: Authorization for indications not approved by the Food and Drug Administration (FDA) must be recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only).

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

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

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:

A. What is the patient's diagnosis?

- Rheumatoid Arthritis
- Juvenile Rheumatoid Arthritis
- Psoriatic Arthritis
- Ankylosing Spondylitis
- Plaque Psoriasis
- Crohn's Disease

B. 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 3 months if patient has responded to treatment, as determined by the prescribing physician • Approved dose is 40 mg subcutaneously every other week

PHYSICIAN STATEMENT

For Medicare only: If none of the above is applicable to this member, please check which, if any, of the following apply:

If none of the above precertification criteria is applicable to this member, please check off which, if any, of the following apply:

1. All covered Part D drugs on any tier of a plan's formulary would not be as effective for the enrollee as the non-formulary drug, and/or would have adverse effects
2. The number of doses available under a dose restriction for the prescription drug:
 - a. Has been ineffective in the treatment of the enrollee's disease or medical condition, or
 - b. Based on sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.
3. The prescription drug alternative(s) listed on the formulary or required to be used in accordance with step therapy requirements:
 - a. Has been ineffective in the treatment of the enrollee's disease or medical condition, or
 - b. Based on sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.

c. Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee.

4. None of the above apply

****If you selected 1, 2, or 3 above, supporting evidence/documentation is required for review. If no supporting evidence/documentation is provided, this request will not be approved.**

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

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YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX