PriorityHealth

Priority Health Medicare prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☐ **Medicare Part B** ☒ **Medicare Part D**
This request is: ☐ **Expedited request** ☐ **Standard request**

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

Humira® (adalimumab)

Member

Last Name: _____ First Name: _____
ID #: _____ DOB: _____ Gender: _____
Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____
Provider Address: _____
Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

☐ New request ☐ Continuation request

Drug product:
☐ Humira Pediatric Crohn's Starter Kit
☐ Humira Starter Kit
☐ Humira Pre-filled Syringe Kit
☐ Humira Pen Injector Kit

Start date (or date of next dose): _____
Date of last dose (if applicable): _____
Dosing frequency: _____

Prior authorization criteria

The following requirements need to be met before this drug is covered by Priority Health Medicare. These requirements have been approved by the Centers for Medicare and Medicaid Services (CMS), but you may ask us for an exception if you believe one or more of these requirements should be waived.

For this drug to be covered, the patient must meet the following criteria:

1. Must be used for a medically accepted indication*
2. For a diagnosis of ankylosing spondylitis:
   - Must have presence of disease for at least 4 weeks
   - Must have a BASDAI score of at least 4
   - Must have documented trial and failure (defined as an inability to improve symptoms) or intolerance to 1 NSAID
3. For a diagnosis of Crohn's disease, psoriatic arthritis, rheumatoid arthritis, or ulcerative colitis:
   - Must have a documented trial and failure (defined as an inability to improve symptoms) or intolerance to one non-biologic immunomodulator (e.g., azathioprine, 6-mercaptopurine, methotrexate)
4. For a diagnosis of psoriasis:
   - Must first have ≥ 5% of body surface area affected (unless hands, feet, head, neck, or genitalia are affected)
   - Must have a documented trial and failure (defined as an inability to improve symptoms) or intolerance to one topical or one non-biologic immunomodulator (e.g., methotrexate, cyclosporine, acitretin)
5. For a diagnosis of hidradenitis suppurativa:
   - Must first have a documented trial and failure (defined as an inability to improve symptoms) or intolerance with systemic or topical antibiotic therapy
6. Prescriber is a specialist or has consulted with a specialist for the condition being treated

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 08/2020
Last reviewed 08/2020

7. Must not use Humira in combination with other biological drugs (e.g., Enbrel)
8. Must be 2 years of age or older

Medically accepted indication*

This drug is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- –– *or* –– supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and Lexi-Drugs.)

Additional information

Note: When criteria are met, coverage duration is 1 year

Precertification Documentation

A. Is the prescriber a specialist or has consulted with a specialist for the condition being treated?

☐ Yes.
☐ No. **Are you asking for an exception to this requirement?**
☐ Yes. ***Rationale for exception***: _____
☐ No

B. Will Humira be used in combination with other biological drugs (e.g., Enbrel)?

☐ No.
☐ Yes. **Are you asking for an exception to this requirement?**
☐ Yes. ***Rationale for exception***: _____
☐ No

C. Answer the applicable questions in the table below.

Condition	Additional requirements for specific indications
(Please check the appropriate box to indicate the patient has met the required criteria	
☐ Hidradenitis suppurativa	**1. Has the patient had a documented trial and failure (defined as an inability to improve symptoms) or intolerance with systemic or topical antibiotic therapy?** ☐ Yes. Check all that apply. ☐ Topical antibiotic therapy ☐ Systemic antibiotic therapy ☐ No. **Are you requesting an exception to the criteria?** ☐ Yes. ***Rationale for exception***: _____ ☐ No

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☐ Psoriatic arthritis ☐ Rheumatoid arthritis ☐ Crohn's disease ☐ Ulcerative colitis	**1. Has the patient had a documented trial and failure (defined as an inability to improve symptoms) or intolerance to 1 non-biologic immunomodulator?** ☐ Yes. ☐ No. **Are you requesting an exception to the criteria?** ☐ Yes. ***Rationale for exception***: _____ ☐ No
☐ Ankylosing spondylitis	**1. Does the patient have a BASDAI score of at least 4?** ☐ Yes. **BASDAI score:** _____ ☐ No. **Are you requesting an exception to the criteria?** ☐ Yes. ***Rationale for exception***: _____ ☐ No **2. Has the patient had presence of disease for at least 4 weeks?** ☐ Yes ☐ No. **Are you requesting an exception to the criteria?** ☐ Yes. ***Rationale for exception***: _____ ☐ No **3. Has the patient had a documented trial and failure (defined as an inability to improve symptoms) or intolerance with 1 NSAID?** ☐ Yes ☐ No. **Are you requesting an exception to the criteria?** ☐ Yes. ***Rationale for exception***: _____ ☐ No
☐ Plaque psoriasis	**1. Is ≥ 5% of BSA affected *or* are hands, feet, head, neck, or genitalia affected?** ☐ Yes ☐ No. **Are you requesting an exception to the criteria?** ☐ Yes. ***Rationale for exception***: _____ ☐ No **2. Has the patient had a documented trial and failure (defined as an inability to improve symptoms) or intolerance to 1 topical or 1 non-biologic immunomodulator?** ☐ Yes. Check all that apply. ☐ Topical drug ☐ One non-biologic immunomodulator (e.g., methotrexate, cyclosporine, acitretin). ☐ No. **Are you requesting an exception to the criteria?** ☐ Yes. ***Rationale for exception***: _____ ☐ No
☐ Other condition	**1. The patient's condition is:** _____ **2. Rationale for use is:** _____

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Priority Health Medicare Exception Request *(exceptions to the above criteria)*

Do you believe one or more of the prior authorization requirements should be waived? ☐ Yes ☐ No
If yes, you must provide a statement explaining the medical reason why the exception should be approved.

Would Humira likely be the most effective option for this patient?
☐ Yes ☐ No
If yes, please explain why: _____

_____

_____

If the patient is currently using Humira, would changing the patient's current regimen likely result in adverse effects for the patient?
☐ Yes ☐ No
If yes, please explain: _____

_____

_____

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