PriorityHealth

Medicaid Pharmacy Prior Authorization Form

Fax completed form to: 877-974-4411 toll free, or 616-942-8206

Humira® (adalimumab)

Patient Information

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Prescriber Information

Prescriber Name: _____ Phone: _____ Fax: _____

Prescriber Address: _____

Prescriber NPI: _____ Office Contact Name: _____

Prescriber Signature: _____ Date: _____

Product Information

☐ Humira 10mg/0.1mL Syringe ☐ Humira 20mg/0.2mL Syringe

☐ Humira 10mg/0.2mL Syringe ☐ Humira 20mg/0.4mL Syringe

☐ Humira 40mg/0.4mL Pen Kit ☐ Humira 40mg/0.4mL Syringe Kit

☐ Humira 40mg/0.8mL Pen Kit ☐ Humira 40mg/0.8mL Syringe Kit

☐ Humira 40mg/0.8mL Crohn's Disease Pediatric Starter Pack Syringe Kit

☐ Humira 40mg/0.8mL Crohn's Disease Starter Pack Pen Kit

☐ Humira 40mg/0.8mL Psoriasis Starter Pack Pen Kit

☐ Humira 80mg/0.8mL Starter Pack Pen

☐ Humira 80mg/0.8mL Crohn's Disease Pediatric Starter Pack Syringe Kit

Requested dose: _____

Requested frequency: _____

Patient weight: _____ ☐ kg ☐ lbs

Clinical Documentation

A. This request is for: ☐ New therapy

☐ Continuation of therapy; When did the patient first start using this medication? _____

B. What diagnosis is this drug being requested for? _____

C. What medications has the patient previously used for this condition?

Drug	Dose	Dates	Clinical Outcome

B. Supporting Information:

_____

_____

_____

All fields must be complete and legible for review. Your office will receive a response via fax. Last reviewed 12/2019

Humira Drug Policy

Criteria contained in this policy only applies to drugs covered on the Priority Health Medicaid formulary. Before coverage of the requested medication is approved, all the following requirements must be met. Documentation supporting the following criteria must be included with this request.

- Must be prescribed by, or in consultation with, a specialist (based on indication, a rheumatologist, dermatologist, gastroenterologist, or ophthalmologist).
- Patient must not use this medication in combination with additional biologic DMARD therapy.

Initial Criteria

- Documentation of a negative TB test in the last 12 months (applies to all diagnosis)

Rheumatoid Arthritis (RA) / Psoriatic Arthritis (PsA)

- Must be age 18 years or older
- Trial and clinical failure with at least one non-biologic DMARD (methotrexate, sulfasalazine, cyclosporine, hydroxychloroquine or leflunomide) for at least 90 consecutive days
- 90-day trial and clinical failure with infliximab, unless there are transportation or other access issues documented
- 90-day trial and clinical failure with of one of the following: Actemra, Xeljanz, Cimzia, or Orencia

Juvenile idiopathic arthritis (JIA)

- Must be age 2 years or older
- Trial and clinical failure with at least one non-biologic DMARD for 3 months *or* prescriber states that there has been rapid disease progression
- 90-day trial and clinical failure with Actemra or Orencia

Plaque Psoriasis (PsO)

- Must be age 18 years or older
- Involvement of greater than 10% of body surface area (unless hands, feet, head, neck, or genitalia are involved)
- Trial and clinical failure with methotrexate for at least 3 consecutive months
- Trial and clinical failure with at least one topical agent plus one additional systemic treatment (acitretin, cyclosporine)
- Trial and clinical failure with UVB or PUVA therapy or contraindication to therapy
- 90-day trial and clinical failure with infliximab, unless there are transportation or other access issues documented
- 90-day trial and clinical failure with Otezla

Ankylosing Spondylitis

- Patient must be age 18 years or older
- Trial and clinical failure with two different NSAIDs totaling 90 consecutive days
- 90 consecutive day trial and clinical failure with steroid products, sulfasalazine, or methotrexate
- 90-day trial and clinical failure with infliximab, unless there are transportation or other access issues documented
- 90-day trial and clinical failure with Cimzia

Crohn's Disease (CD) / Ulcerative Colitis (UC)

- Trial and clinical failure with oral or intravenous corticosteroids for at least one month
- Trial and clinical failure of one or more of the following for 90 consecutive days in the previous 120-day period to
    - Azathioprine
    - Budesonide capsules
    - Oral aminosalicylates (ex: mesalamine, sulfasalazine, balsazide disodium)
    - Rectal aminosalicylates
    - Cyclosporine
    - Mercaptopurine
- For patients age 18 years and older, 90-day trial and clinical failure with infliximab, unless there are transportation or other access issues documented
- 90-day trial and clinical failure with Cimzia (for Crohn's Disease only)

Pediatric Crohn's Disease

- Patient must be age 6 years or older
- Patient has trialed and experienced an inadequate response to TWO of the following:
    - Corticosteroids
    - Azathioprine
    - Methotrexate
- For patients age 18 years and older, 90-day trial and clinical failure with infliximab, unless there are transportation or other access issues documented

All fields must be complete and legible for review. Your office will receive a response via fax. Last reviewed 12/2019

Severe Crohn's Disease / Severe Ulcerative Colitis

For requests to dose more frequently than every other week, the following additional criteria must be met:

- Patient must have previously responded to every other week dosing
- Patient must be experiencing a flare
- The flare must be likely to result in hospitalization
- When criteria is met, up to a 2-month approval will be issued for treatment of the flare and then medication must be resumed at every other week dosing.

Non-Infectious Uveitis

- Trial and clinical failure of periocular, intraocular, or systemic corticosteroids
- Trial and clinical failure of immunosuppressive drugs (e.g., azathioprine, cyclosporine, mycophenolate or methotrexate) at maximally tolerated doses
- For patients age 18 years and older, 90-day trial and clinical failure with infliximab, unless there are transportation or other access issues documented

Hidradenitis Suppurativa

- Clinically diagnosed with severe and refractory hidradenitis suppurativa
- Documentation of use of general measures:
    - Education and support
    - Avoidance of skin trauma
- Documentation of inadequate response to intralesional corticosteroids
- Documentation of inadequate response to procedural interventions (punch debridement) in combination with pharmacologic therapies
- Documentation of trial and clinical failure with systemic and topical antibiotic therapy
    - 3 months of topical antibiotics
    - 3 months of doxycycline
    - 3 months of clindamycin plus rifampin
- For patients age 18 years and older, 90-day trial and clinical failure with infliximab, unless there are transportation or other access issues documented

Continuation Criteria

- Must be prescribed for one of the diagnosis listed above.
- Documentation showing the patient has experienced symptomatic improvement or maintained stable clinical status.

Additional Information

- Approvals for both initial therapy and continuation of therapy will be issued for up to 2 years.
- Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy **OR** no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.
- If a contraindication or intolerance to a qualifying medication exists, detailed supporting documentation must be submitted.
- Infliximab is covered under the Medical benefit.

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

All fields must be complete and legible for review. Your office will receive a response via fax. Last reviewed 12/2019