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 40 mg Crohn's Disease Starter
- ☐ Humira 40 mg Pre-filled Pen
- ☐ Humira 40 mg Pre-filled Syringe
- ☐ Humira 40 mg Psoriasis Starter
- ☐ Humira 20 mg Pediatric Pre-filled Syringe
- ☐ Humira 40 mg Pre-filled Pen, citrate-free
- ☐ Humira 40 mg Pre-filled Syringe, citrate-free

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*
   - For ankylosing spondylitis
     i. Must have a BASDAI score of at least 4
     ii. Must have presence of active disease for at least 4 weeks
   - For moderate to severe plaque psoriasis
     i. Must have > 5% body surface area affected (unless hands, feet, head, neck, or genitalia involved)
2. Must have a negative TB test (must be done yearly)
3. Must be 2 years of age or older

Additional information

Note: When criteria are met, duration of approval is 1 year

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 01/2019
Last reviewed 01/2019

PriorityHealth

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 and the DRUGDEX Information System)

Priority Health Precertification Documentation

A. What is the date and result of the patient's most recent TB test?

- ☐ Negative **Date:** _____
- ☐ Positive
- ☐ Not completed. **Are you requesting an exception to the criteria?**
  - ☐ Yes. ***Rationale for exception***: _____
  - ☐ No

B. What condition is this drug being requested for?

- ☐ Ankylosing spondylitis
  1. **Does the patient have a BASDAI score of 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 active disease for at least 4 weeks?**
     - ☐ Yes
     - ☐ No. **Are you requesting an exception to the criteria?**
       - ☐ Yes. ***Rationale for exception***: _____
       - ☐ No
- ☐ Plaque psoriasis
  1. **Does the patient's psoriasis affect one of the following?**
     - ☐ more than 5% body surface area
     - ☐ hands
     - ☐ genitalia
     - ☐ feet
     - ☐ neck
     - ☐ head
     - ☐ None. **Are you requesting an exception to the criteria?**
       - ☐ Yes. ***Rationale for exception***: _____
       - ☐ No
- ☐ Crohn's disease
- ☐ Juvenile idiopathic arthritis
- ☐ Psoriatic arthritis
- ☐ Rheumatoid arthritis
- ☐ Hidradenitis suppurativa
- ☐ Ulcerative colitis
- ☐ Uveitis
- ☐ *Other – the patient's condition is:* _____
  Rationale for Other use: _____

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Last reviewed 01/2019

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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Last reviewed 01/2019