PriorityHealth

Pharmacy Prior Authorization Form

For Prior Authorization, please fax to: 877 974-4411 toll free, or 616 942-8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial Individual (Optimized)**
☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

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/0.8 mL Crohn's Starter Pack
- ☐ Humira 40 mg/0.8 mL prefilled pen
- ☐ Humira 40 mg/0.8 mL prefilled syringe
- ☐ Humira 40 mg/0.8 mL Psoriasis Starter Pack
- ☐ Humira 20 mg/0.4 mL Ped Crohn's Starter Pack
  - ☐ 3-pack ☐ 6-pack
- ☐ Humira 20 mg/0.4 mL prefilled syringe
- ☐ Humira 10 mg/0.2 mL prefilled syringe

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Patient's weight: _____

HUMIRA COVERAGE POLICY

- Before Humira is covered, the patient must meet all of the General Criteria for Humira and all of the Specific Criteria for the treatment diagnosis. If these criteria are not met, the prescriber must provide an explanation of why an exception to the criteria is necessary.
- Coverage for a diagnosis not listed below will be considered on a case by case basis. Please provide rationale for use and all pertinent patient information.
- Humira will not be covered in combination with another biologic drug.
- Please provide rationale when requesting any dose or dosing interval not listed in the FDA label.

Criteria

General Initiation Criteria for ALL Diagnoses:

a) Patient has evidence of a negative TB test result in the past 12 months (or TB is adequately managed); AND
b) Patient does not have moderate to severe heart failure (or heart failure is adequately managed); AND
c) 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.
Updated 07/2017
Last reviewed 05/2019

Specific Initiation Criteria for Individual Diagnoses:

1. Ankylosing Spondylitis
   There are no Specific Initiation Criteria for this indication. Humira is covered for any patient who meets the above General Initiation Criteria.

2. Crohn's Disease.
   a) Patient has tried or is currently taking corticosteroids (such as prednisone or methylprednisolone); OR
   b) Patient has tried at least ONE other agent for this condition (e.g., azathioprine, 6-mercaptopurine, methotrexate, Cimzia, Remicade, Entyvio, or Stelara) for a period of at least 3 months; OR
   c) Patient has enterocutaneous (perianal or abdominal) or rectovaginal fistula; OR
   d) Patient has had ileocolonic resection (to reduce the chance of Crohn's disease recurrence).

3. Hidradenitis Suppurativa
   a) Patient has tried at least ONE other agent for this condition (e.g., intralesional or oral corticosteroids [such as triamcinolone or prednisone], or systemic antibiotics [such as clindamycin, dicloxacillin, or erythromycin], or isotretinoin.

4. Juvenile Idiopathic Arthritis
   a) Patient has tried at least ONE other agent for this condition (e.g., a conventional synthetic DMARD [such as methotrexate, sulfasalazine, or leflunomide], or a nonsteroidal anti-inflammatory drug [NSAID], or a biologic DMARD [such as Orencia, Enbrel, Kineret, or Actemra]) for a period of at least 3 months; OR
   b) Patient will be starting on Humira concurrently with methotrexate, sulfasalazine, or leflunomide; OR
   c) Patient has aggressive disease, as determined by the prescribing physician.

5. Plaque Psoriasis
   a) Patient has tried **ALL** of the following for a period of at least 3 months:
      a. One topical agent
      b. One non-biologic systemic agent (e.g., methotrexate [MTX], cyclosporine, acitretin)
      c. Phototherapy

6. Psoriatic Arthritis
   a) Patient has tried at least ONE conventional systemic DMARD (such as methotrexate, leflunomide, sulfasalazine, or azathioprine) for a period of at least 3 months.

7. Rheumatoid Arthritis
   a) Patient has tried at least ONE conventional systemic DMARD (such as methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine) for a period of at least 3 months.

8. Ulcerative Colitis
   a) Patient has tried ONE systemic agent (e.g., 6-mercaptopurine, azathioprine, cyclosporine, tacrolimus, Remicade, Simponi, or a corticosteroid [such as prednisone or methylprednisolone]) for a period of at least 2 months; OR
   b) The patient has pouchitis AND has tried therapy with an antibiotic (such as metronidazole or ciprofloxacin), probiotic, corticosteroid enema (such as hydrocortisone), or mesalamine enema.

9. Uveitis – noninfectious intermediate, posterior and panuveitis
   a) The patient has tried ONE other agent for this condition (e.g., periocular, intraocular, or systemic corticosteroids [such as triamcinolone, betamethasone, methylprednisolone, or prednisone], immunosuppressives [such as methotrexate, mycophenolate mofetil, cyclosporine, azathioprine, or cyclophosphamide], Enbrel, or Remicade).

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.

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PriorityHealth

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ Ankylosing spondylitis
- ☐ Crohn's disease
- ☐ Hidradenitis suppurativa
- ☐ Juvenile idiopathic arthritis
- ☐ Plaque psoriasis
- ☐ Psoriatic arthritis
- ☐ Rheumatoid arthritis
- ☐ Ulcerative colitis
- ☐ Uveitis
- ☐ Other – the patient's condition is: _____

  Rationale for use: _____

B. Has the patient had a negative TB test result in the past 12 months?

- ☐ Yes Date: _____
- ☐ No, rationale for use: _____

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

- ☐ Yes Date: _____
- ☐ No, rationale for use: _____

D. Will the patient be receiving other biologic therapy in combination with Humira?

☐ No ☐ Yes, rationale for use: _____

E. Which of the following has the patient had a documented therapeutic trial with?

Category	Drug		Dates of Use
NSAID	☐ Diclofenac ☐ Ibuprofen ☐ Indomethacin	☐ Meloxicam ☐ Naproxen	
Traditional non-biologic systemic DMARDs & immunosuppressives	☐ 6-Mercaptopurine ☐ Acitretin ☐ Azathioprine ☐ Cyclophosphamide ☐ Cyclosporine ☐ Hydroxychloroquine	☐ Leflunomide ☐ Methotrexate ☐ Mycophenolate ☐ PUVA ☐ Sulfasalazine	
Biologics	☐ Actemra ☐ Cimzia ☐ Cosentyx ☐ Enbrel ☐ Entyvio	☐ Kineret ☐ Orencia ☐ Remicade ☐ Simponi ☐ Stelara	
Corticosteroids	☐ Betamethasone ☐ Methylprednisolone	☐ Prednisone ☐ Triamcinolone	
Systemic antibiotics	☐ Clindamycin ☐ Dicloxacillin	☐ Erythromycin ☐ Azathioprine	
Retinoids	☐ Isotretinoin		
Other (please fill in)	☐ ☐		

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The following questions are required for **plaque psoriasis** only:

F. Has the patient had a trial with one or more topical agents for a period of at least 3 months?

- ☐ Yes
- ☐ No – rationale for use: _____

G. Has the patient had a trial with phototherapy for a period of at least 3 months?

- ☐ Yes, UVA
- ☐ Yes, UVB
- ☐ No – rationale for use: _____

H. Has the patient had a trial with one or more non-biologic systemic agents for a period of at least 3 months?

- ☐ No – rationale for use: _____
- ☐ Yes – Please mark the agent(s) tried and failed above.

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