



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Humira® (adalimumab)

Phone: 215-991-4300 Fax back to: 866-240-3712

HEALTH PARTNERS manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please print clearly.**

Patient Name:	Physician Name:
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Group Number:	NPI: State Lic. Id:
Address:	Address:
City, State, Zip:	City, State, Zip:

Drug Name: Expedited/Urgent

Directions:

Please answer the following questions and sign below:
Q1. What is the requested duration of therapy? 6 months or less More than 6 months
Q2. What is the prescriber's specialty? Rheumatologist Dermatologist Gastroenterologist Other
Q3. If Other, please specify:
Q4. What is the patient's diagnosis? Moderate to severe active Rheumatoid Arthritis Psoriatic Arthritis Chronic moderate to severe Plaque Psoriasis Moderately to severely active Polyarthricular Juvenile Idiopathic Arthritis Active Ankylosing Spondylitis Crohn's Disease Other
Q5. If Other, please specify:
Q6. For Rheumatoid Arthritis, Psoriatic Arthritis: Has the patient failed or had an inadequate response to the trial of at least one or more DMARD OR is intolerant to DMARDs. [e.g., Imuran® (azathioprine), Ridaura® (oral gold), Plaquenil® (hydroxychloroquine), Cuprimine® (D-penicillamine), Azulfidine® (sulfasalazine), methotrexate and NSAIDs]? Yes No
Q7. For Psoriasis: What is the extent of the body involvement? Less than 10% Equal to or greater than 10%
Q8. For Psoriasis (less than 10% of the body surface area involvement): Has the patient failed or had an inadequate



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response to the trial of, Tar, 1 topical steroid (high to very high potency) and Dovonex or Anthralin?
 Yes No

Q9. For Psoriasis (equal to or greater than 10% of the body involvement): Has the patient failed or had an inadequate response to the trial of Methotrexate OR UVB therapy (alone or in combination with other medications) OR Soriatane (also requires prior authorization)?
 Yes No

Q10. For polyartricular juvenile idiopathic arthritis: Is the patient equal to or greater than 4 years old?
 Yes No

Q11. For Moderately to severely active polyarticular-course juvenile rheumatoid arthritis (greater than or equal to 4 years old): Has the patient failed or had an inadequate response to the trial of one or more DMARD or is intolerant to DMARDs. [e.g., NSAIDs, Azulfudine® (sulfasalazine), methotrexate, Imuran® (azathioprine), Ridaura® (oral gold), cyclosporine, prednisone]?
 Yes No

Q12. For Ankylosing spondylitis: Has the patient failed or had an inadequate response to the trial of at least one ore more DMARD or is intolerant to DMARDs. [e.g., NSAIDs, Azulfudine® (sulfasalazine), methotrexate]?
 Yes No

Q13. For Crohn's disease: Has the patient failed or had an inadequate response or is intolerant to a trial of corticosteroids and methotrexate or azathioprine, or has lost response to or is intolerant to Infliximab(Remicade®)?
 Yes No

Q14. Has the patient been evaluated for active or latent tuberculosis infection with a tuberculin skin test prior to the initiation of therapy?
 Yes No

Q15. For tuberculin testing: If latent infection is diagnosed, has appropriate prophylaxis in accordance with the CDC and prevention guidelines been instituted?
 Yes No Not applicable

Q16. Deliver to:
 Physician's Office Home Delivery

Q17. Delivery date needed:

Physician Signature

Date