

HUMIRA (adalimumab) (preferred) PRIOR AUTHORIZATION FORM

Cytokine and CAM Antagonists and Quantity Limits/Daily Dose Limits prior authorization guidelines are accessible on the Department's Pharmacy Services website at <http://www.dhs.pa.gov/provider/pharmacyservices/index.htm>.

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info	Total # of pages: _____	
<input type="checkbox"/> Renewal request	(PA#: _____)	Prescriber name: _____	
Name of office contact: _____		Specialty: _____	
Contact's phone number: _____		State license #: _____	
LTC facility contact/phone: _____		NPI: _____	MA Provider ID#: _____
RECIPIENT INFORMATION		Street address: _____	
Recipient Name: _____		Suite #: _____	City/state/zip: _____
Recipient ID#: _____	DOB: _____	Phone: _____	Fax: _____

CLINICAL INFORMATION

Product requested:	<input type="checkbox"/> Humira 10 mg/0.2 ml syringe	<input type="checkbox"/> Humira Starter Pack (CD, UC, HS) 40 mg/0.8 ml pen (6 pens/package)	
	<input type="checkbox"/> Humira 20 mg/0.4 ml syringe	<input type="checkbox"/> Humira Psoriasis Starter Pack 40 mg/0.8 ml pen (4 pens/package)	
	<input type="checkbox"/> Humira 40 mg/0.8 ml syringe	<input type="checkbox"/> Humira Pediatric Crohn's Starter kit 40 mg/0.8 ml syringe for < 88 lbs (3 syringes/package)	
	<input type="checkbox"/> Humira 40 mg/0.8 ml pen	<input type="checkbox"/> Humira Pediatric Crohn's Starter kit 40 mg/0.8 ml syringe for ≥ 88 lbs (6 syringes/package)	
Directions: _____	Quantity: _____	Refills: _____	Recipient's weight: _____ lbs/kg
Diagnosis (<i>submit documentation</i>): _____			Diagnosis code (<i>required</i>): _____

ALL requests

1. **Specialty Pharmacy Drug Program:** What Specialty Pharmacy will be used? Diplomat Specialty Walgreens Specialty
2. Check all that apply to the Recipient and *submit documentation for each*.
 screened for hepatitis B (antibody and/or surface antigen) and tuberculosis up-to-date with all age-appropriate immunizations

INITIAL requests – complete questions applicable to Recipient's diagnosis

3. **Ankylosing spondylitis or psoriatic arthritis:** Does the Recipient have a history of trial and failure, contraindication, or intolerance of the following?
 six-week trial each of at least 2 different NSAIDs Yes No *Submit documentation of all medications tried and outcomes.*
 three-month trial of methotrexate or other DMARD
4. **Crohn's disease or ulcerative colitis:** Does the Recipient have a history of trial and failure, contraindication, or intolerance of the following?
 aminosaliclates corticosteroids immunomodulators Yes No *Submit documentation of all medications tried and outcomes.*
5. **Rheumatoid arthritis or juvenile idiopathic arthritis:** Does the Recipient have a history of trial and failure, contraindication, or intolerance of at least 3 months of treatment with methotrexate or another DMARD?
 Yes No *Submit documentation of all medications tried and outcomes.*
6. **Plaque psoriasis:** Does at least one of the following apply to the Recipient?
 at least 10% of body surface area (BSA) is affected Yes No *Submit documentation.*
 critical areas of the body are involved (face, palms, soles, and/or genitals)
7. **Plaque psoriasis:** Does the Recipient have a history of trial and failure, contraindication, or intolerance of a 3-month trial of the following treatments? *Check all that apply.*
 PUVA UVB light with either coal tar or dithranol Yes No *Submit documentation treatments tried and outcomes.*
8. **Plaque psoriasis:** Does the Recipient have a history of trial and failure, contraindication, or intolerance of the following medications? *Check all that apply.*
 acitretin cyclosporine methotrexate Yes No *Submit documentation of all medications tried and outcomes.*
9. **Hidradenitis suppurativa and uveitis,** answer questions 1 and 2 and submit to Pharmacy Services.
10. **All other diagnoses:** Submit documentation supporting the use of Humira for the Recipient's diagnosis.

RENEWAL requests

1. *Submit documentation of how the requested medication has helped the Recipient's condition and level of functioning.*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature: _____	Date: _____
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