pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

HUMIRA [preferred] & biosimilars [non-preferred] (adalimumab) PRIOR AUTHORIZATION FORM

Cytokine and CAM Antagonists and **Quantity Limits/Daily Dose Limits** prior authorization guidelines: http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		MA provider ID:	
LTC facility contact/phone:		NPI:	State license #:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Product requested: ☐Humira ☐Humira CF ☐other: _____		Strength & formulation/packaging: (i.e., syringe, pen, starter pack, etc)	
Directions:	Qty:	Refills:	Beneficiary's weight: _____ lbs/kg
Diagnosis (*submit documentation*):			Dx code (*required*):

Specialty Pharmacy Drug Program: Which specialty pharmacy will be used? ☐Diplomat Specialty ☐Walgreen's Specialty

INITIAL requests – complete questions applicable to beneficiary's diagnosis

1. ***All diagnoses***: Check all that apply to the beneficiary and *submit documentation for each*. ☐vaccinated for hepatitis B ☐up-to-date with all age-appropriate immunizations ☐screened for hepatitis B (surface antigen & core antibody) ☐screened for tuberculosis		
2. ***Ankylosing spondylitis or psoriatic arthritis***: Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the following? ☐four-week trial each of at least 2 different NSAIDs ☐eight-week trial of methotrexate or other DMARD *(does not apply to axial disease)*	☐Yes ☐No	*Submit documentation of all medications tried and outcomes.*
3. ***Crohn's disease or ulcerative colitis:*** Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the following? ☐aminosalicylates ☐corticosteroids ☐immunomodulators	☐Yes ☐No	*Submit documentation of all medications tried and outcomes.*
4. ***Rheumatoid arthritis:*** Does the beneficiary 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.*
5. ***Plaque psoriasis:*** Does at least one of the following apply to the beneficiary? ☐at least 5% of body surface area (BSA) is affected ☐critical areas of the body are involved (face, palms, soles, and/or genitals)	☐Yes ☐No	*Submit documentation.*
6. ***Plaque psoriasis:*** Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the following treatments and medications? *Check all that apply.* ☐3 months PUVA ☐3 months UVB light ☐acitretin ☐cyclosporine ☐methotrexate	☐Yes ☐No	*Submit documentation of treatments and medications tried and outcomes.*
7. ***Uveitis***: Check all of the following that apply to the beneficiary and *submit documentation for each*. ☐has a diagnosis of uveitis associated with juvenile idiopathic arthritis or Behçet's disease ☐has steroid-dependent uveitis (i.e., requires ≥ prednisone 7.5 mg daily [or equivalent]) with plan to taper or discontinue systemic steroids ☐has a documented history of trial & failure, contraindication, or intolerance of systemic immunosuppressives or corticosteroids (systemic, topical, intraocular, or periocular)		
8. ***Hidradenitis suppurativa*** and ***juvenile idiopathic arthritis:*** Answer questions 1 and 2 and submit documentation to Pharmacy Services.		
9. ***All other diagnoses:*** Submit documentation supporting the use of Humira for the beneficiary's diagnosis & other treatments tried.		
10. ***For a biosimilar product***: Submit documentation of trial and failure, contraindication, or intolerance to Humira or use of biosimiliar in past 90 days.		

RENEWAL requests

1. *Submit documentation of how the requested medication has helped the beneficiary'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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