HUMIRA [PREFERRED] AND BIOSIMILARS [NON-PREFERRED] (ADALIMUMAB) PRIOR AUTHORIZATION FORM

(form effective 1/1/20)

AmeriHealth Caritas Pennsylvania | PerformRx℠ Next Generation Pharmacy Benefits

Fax to PerformRx℠ at **1-888-981-5202**, or to speak to a representative call **1-866-610-2774.**

PRIOR AUTHORIZATION REQUEST INFORMATION

☐ New request ☐ Renewal request	# of pages:	Name of office contact:
Contact's phone number:		LTC facility contact/phone:

PATIENT INFORMATION

Patient name:	Patient ID #:	DOB:
Street address:	Apt. #:	City/state/zip:

PRESCRIBER INFORMATION

Prescriber name:	Specialty:	
State license #:	NPI:	MA Provider ID #
Street address:	Suite #:	City/state/zip:
Phone:	Fax:	

CLINICAL INFORMATION

Product requested: ☐ Humira ☐ Humira CF ☐ other: _____

Strength and formulation/packaging (i.e., syringe, pen, starter pack, etc.):

Directions:	Qty:	Refills:	Patient's weight:_____ lbs/kg
Diagnosis (submit documentation):			Dx code *(required)*:

PHARMACY INFORMATION (Prescriber to identify the pharmacy that is to dispense the medication):

Deliver to: ☐ Patient's Home ☐ Physician's Office ☐ Patient's Preferred Pharmacy Name:

Pharmacy Phone #:	Pharmacy Fax #:

☐ I acknowledge that the patient agrees with the pharmacy chosen for delivery of this medication.

INITIAL REQUESTS (Complete questions applicable to patient's diagnosis):

1. All diagnoses: Check all that apply to the patient and submit documentation for each.
   ☐ vaccinated for hepatitis B ☐ screened for hepatitis B (surface antigen and core antibody) ☐ up-to-date with all age-appropriate immunizations
   ☐ screened for tuberculosis
2. Ankylosing spondylitis or psoriatic arthritis: Does the patient 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 – *List medications tried:* _____ ☐ No
3. Crohn's disease or ulcerative colitis: Does the patient have a history of trial and failure, contraindication, or intolerance of the following?
   ☐ aminosalicylates ☐ corticosteroids ☐ immunomodulators ☐ Yes – *List medications tried:*_____ ☐ No
4. Rheumatoid arthritis: Does the patient have a history of trial and failure, contraindication, or intolerance of at least 3 months of treatment with methotrexate or another DMARD? ☐ Yes – *List medications tried:* _____ ☐ No
5. Plaque psoriasis: Does at least one of the following apply to the patient?
   ☐ 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 patient 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 patient 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 and failure, contraindication, or intolerance of systemic immunosuppressives or corticosteroids (systemic, topical, intraocular, or periocular)
   List medications tried:_____
8. Hidradenitis suppurativa and juvenile idiopathic arthritis: Answer questions 1 and 2 and submit documentation.
9. All other diagnoses: Submit documentation supporting the use of Humira for the patient's diagnosis and 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 patient's condition and level of functioning.*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date: