Please note: All information below is required to process this request.
Mon-Fri: 6am to 6pm Eastern / Sat: 6am to 6pm Eastern

Humira® Prior Authorization Request Form (Page 1 of 2)

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Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

- ❑ Ankylosing spondylitis
- ❑ Juvenile arthritis
- ❑ Moderate to severe Crohn's disease
- ❑ Moderate to severe hidradenitis suppurativa (HS)
- ❑ Moderately to severely active ulcerative colitis
- ❑ Non-infectious uveitis
- ❑ Plaque psoriasis
- ❑ Psoriatic arthritis
- ❑ Rheumatoid arthritis
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Prescriber's Specialty:

Select if the prescriber is one of the following specialists:

❑ Dermatologist ❑ Gastroenterologist ❑ Rheumatologist

For ankylosing spondylitis, juvenile arthritis, psoriatic arthritis or rheumatoid arthritis, also answer the following:

Select if the patient has tried and failed the following disease modifying antirheumatic drug (DMARD) therapies for at least three (3) months:

❑ 6-mercaptopurine ❑ Auranofin ❑ Hydroxychloroquine ❑ Methotrexate
❑ Aminosalicylates ❑ Azathioprine ❑ Leflunomide ❑ Sulfasalazine

For moderate to severe Crohn's disease, also answer the following:

Has the patient had an inadequate response to budesonide or high dose steroids (40 to 60 mg prednisone)? ❑ **Yes** ❑ **No**

Select if the patient has had inadequate response to the following DMARD therapies for at least three (3) months:

❑ 6-mercaptopurine ❑ Auranofin ❑ Hydroxychloroquine ❑ Methotrexate
❑ Aminosalicylates ❑ Azathioprine ❑ Leflunomide ❑ Sulfasalazine

For moderate to severe hidradenitis suppurativa (HS), also answer the following:

Has the patient been diagnosed with HS for at least one (1) year? ❑ **Yes** ❑ **No**

Select if he following applies to the patient:

- ❑ HS lesions are in at least two (2) distinct areas of the body
- ❑ HS lesions are in one area of the body

Select the patient's HS stage:

- ❑ Hurley stage II (defined as one or more widely separated recurrent abscesses with tract formation and scars)
- ❑ Hurley stage III (defined as multiple interconnected tracts and abscesses throughout an entire area)

Has the patient tried and failed a 90-day treatment of oral antibiotics for HS? ❑ **Yes** ❑ **No**

If "yes" to the above question, document the name of the antibiotic tried: _____ Date tried: _____

Humira® Prior Authorization Request Form (Page 2 of 2)

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For moderately to severely active ulcerative colitis, also answer the following:

Select if the patient has had inadequate response to the following:

- ❑ Aminosalicylate (for at least 3 months)
- ❑ High dose steroids (40 to 60 mg prednisone)

For non-infectious uveitis, also answer the following:

Select if the patient has the following disease characteristics:

- ❑ Chronic
- ❑ Recurrent
- ❑ Treatment-refractory
- ❑ Vision-threatening disease

Select if the patient has tried and failed the following therapies for at least three (3) months:

- ❑ Acitretin
- ❑ Azathioprine
- ❑ Cyclosporine
- ❑ Leflunomide
- ❑ Methotrexate

Has the patient tried and failed corticosteroid therapy (prednisone 60 mg/day)? ❑ **Yes** ❑ **No**

For plaque psoriasis, also answer the following:

Does the patient have at least one (1) fingernail with nail psoriasis? ❑ **Yes** ❑ **No**

Does the patient have disease that affects more than 10% of the patient's body surface area? ❑ **Yes** ❑ **No**

Select if the patient's psoriasis involves the following areas:

- ❑ Face
- ❑ Genitalia
- ❑ Palms
- ❑ Soles

Select if the patient has tried and failed the following phototherapies (UV light therapies):

- ❑ NB UV-B
- ❑ PUVA

Select if the patient has tried and failed the following alternative oral systemic therapies:

- ❑ Acitretin
- ❑ Cyclosporine
- ❑ Methotrexate

Medication being provided by: (Please check applicable box below)

❑ Physician's office ❑ PropriumRx ❑ Specialty Pharmacy (specify name): _____

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****
Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

Prescriber Signature: _____ **Date:** _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.