



This form is based on Express Scripts standard criteria and may not be applicable to all patients; certain plans and situations may require additional information beyond what is specifically requested.
Additional forms available: www.express-scripts.com/pa

Fax completed form to **1-800-357-9577**
If this an **URGENT** request, please call 1-800-417-8164

Patient Information	
Patient First Name:	_____
Patient Last Name:	_____
Patient ID#:	_____
Patient DOB:	_____
Patient Phone #:	_____

Prescriber Information	
Prescriber Name:	_____
Prescriber DEA/NPI (required):	_____
Prescriber Phone #:	_____
Prescriber Fax #:	_____
Prescriber Address:	_____
State:	_____ Zip Code: _____

Primary Diagnosis: _____	ICD Code: _____
--------------------------	-----------------

Please indicate which drug and strength is being requested:

- | | |
|--|--|
| <input type="checkbox"/> Humira 20mg/0.4ml Syringe (Kit) | <input type="checkbox"/> Humira 40mg/0.8ml Pen (Kit) |
| <input type="checkbox"/> Humira 40mg/0.8ml Crohn's Disease Starter Pen (Kit) | <input type="checkbox"/> Humira 40mg/0.8ml Syringe (Kit) |
| <input type="checkbox"/> Humira 40mg/0.8ml Psoriasis Starter Pen (Kit) | <input type="checkbox"/> Other _____ |

Directions for use (i.e. QD, BID, PRN & Qty): _____

Please complete the clinical assessment:		
1. Has the patient been started on Humira?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. What is the indication or diagnosis?		
<input type="checkbox"/> Ankylosing spondylitis <input type="checkbox"/> Behcet's disease <input type="checkbox"/> Crohn's disease, active <input type="checkbox"/> Hidradenitis suppurativa <input type="checkbox"/> Juvenile rheumatoid arthritis (JRA) or Juvenile idiopathic arthritis (JIA) <input type="checkbox"/> Plaque psoriasis <input type="checkbox"/> Psoriatic arthritis	<input type="checkbox"/> Pyoderma gangrenosum <input type="checkbox"/> Rheumatoid arthritis in adults <input type="checkbox"/> Sarcoidosis <input type="checkbox"/> Undifferentiated spondylarthritis (undifferentiated arthritis) <input type="checkbox"/> Uveitis (noninfectious) in children or adults <input type="checkbox"/> Other: _____	

<p>3. Is Humira to be given in combination with any of the following DMARDS:</p> <table border="0"> <tr> <td><input type="checkbox"/> Actemra (tocilizumab)</td> <td><input type="checkbox"/> Orencia (abatacept)</td> </tr> <tr> <td><input type="checkbox"/> Amevive (alefacept)</td> <td><input type="checkbox"/> Rituxan (rituximab)</td> </tr> <tr> <td><input type="checkbox"/> Cimzia (certolizumab pegol)</td> <td><input type="checkbox"/> Simponi (golimumab)</td> </tr> <tr> <td><input type="checkbox"/> Enbrel (etanercept)</td> <td><input type="checkbox"/> Stelara (ustekinumab)</td> </tr> <tr> <td><input type="checkbox"/> Kineret (anakinra)</td> <td><input type="checkbox"/> Other: _____</td> </tr> <tr> <td><input type="checkbox"/> Methotrexate [MTX] (oral, injection)</td> <td>_____</td> </tr> </table>	<input type="checkbox"/> Actemra (tocilizumab)	<input type="checkbox"/> Orencia (abatacept)	<input type="checkbox"/> Amevive (alefacept)	<input type="checkbox"/> Rituxan (rituximab)	<input type="checkbox"/> Cimzia (certolizumab pegol)	<input type="checkbox"/> Simponi (golimumab)	<input type="checkbox"/> Enbrel (etanercept)	<input type="checkbox"/> Stelara (ustekinumab)	<input type="checkbox"/> Kineret (anakinra)	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Methotrexate [MTX] (oral, injection)	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A				
<input type="checkbox"/> Actemra (tocilizumab)	<input type="checkbox"/> Orencia (abatacept)																		
<input type="checkbox"/> Amevive (alefacept)	<input type="checkbox"/> Rituxan (rituximab)																		
<input type="checkbox"/> Cimzia (certolizumab pegol)	<input type="checkbox"/> Simponi (golimumab)																		
<input type="checkbox"/> Enbrel (etanercept)	<input type="checkbox"/> Stelara (ustekinumab)																		
<input type="checkbox"/> Kineret (anakinra)	<input type="checkbox"/> Other: _____																		
<input type="checkbox"/> Methotrexate [MTX] (oral, injection)	_____																		
<p>4. Has the patient tried one DMARD (brand or generic; oral or injectable) for at least 2 months? If different duration other than 2 months, please specify: _____</p> <table border="0"> <tr> <td><input type="checkbox"/> Actemra</td> <td><input type="checkbox"/> Orencia</td> </tr> <tr> <td><input type="checkbox"/> Arava (leflunomide)</td> <td><input type="checkbox"/> Plaquenil (hydroxychloroquine)</td> </tr> <tr> <td><input type="checkbox"/> Cimzia</td> <td><input type="checkbox"/> Remicade</td> </tr> <tr> <td><input type="checkbox"/> Enbrel</td> <td><input type="checkbox"/> Rituxan</td> </tr> <tr> <td><input type="checkbox"/> Kineret</td> <td><input type="checkbox"/> Simponi</td> </tr> <tr> <td><input type="checkbox"/> Methotrexate [MTX] (oral, injection)</td> <td><input type="checkbox"/> Sulfasalazine</td> </tr> <tr> <td><input type="checkbox"/> Imuran (azothiaprine)</td> <td><input type="checkbox"/> Other: _____</td> </tr> <tr> <td><input type="checkbox"/> 6-mercaptopurine</td> <td>_____</td> </tr> </table>	<input type="checkbox"/> Actemra	<input type="checkbox"/> Orencia	<input type="checkbox"/> Arava (leflunomide)	<input type="checkbox"/> Plaquenil (hydroxychloroquine)	<input type="checkbox"/> Cimzia	<input type="checkbox"/> Remicade	<input type="checkbox"/> Enbrel	<input type="checkbox"/> Rituxan	<input type="checkbox"/> Kineret	<input type="checkbox"/> Simponi	<input type="checkbox"/> Methotrexate [MTX] (oral, injection)	<input type="checkbox"/> Sulfasalazine	<input type="checkbox"/> Imuran (azothiaprine)	<input type="checkbox"/> Other: _____	<input type="checkbox"/> 6-mercaptopurine	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> Actemra	<input type="checkbox"/> Orencia																		
<input type="checkbox"/> Arava (leflunomide)	<input type="checkbox"/> Plaquenil (hydroxychloroquine)																		
<input type="checkbox"/> Cimzia	<input type="checkbox"/> Remicade																		
<input type="checkbox"/> Enbrel	<input type="checkbox"/> Rituxan																		
<input type="checkbox"/> Kineret	<input type="checkbox"/> Simponi																		
<input type="checkbox"/> Methotrexate [MTX] (oral, injection)	<input type="checkbox"/> Sulfasalazine																		
<input type="checkbox"/> Imuran (azothiaprine)	<input type="checkbox"/> Other: _____																		
<input type="checkbox"/> 6-mercaptopurine	_____																		
<p>5. Will Humira be given as an intra-articular injection?</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A																
<p>6. <u>If the diagnosis is rheumatoid arthritis in adults</u>, does the patient have joint erosions OR important markers of poor prognosis such as functional limitations, rheumatoid factor positivity and/or positive anti-cyclic citrullinated peptide (CCP) antibodies, or extraarticular manifestations of rheumatoid arthritis?</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A																
<p>7. <u>If the diagnosis is Crohn's disease, active, in adolescents equal to or greater than 15 years and adults</u>, has the patient already had 2 doses of Humira to induce response/remission OR has the patient received 12 weeks of therapy with Humira?</p> <p style="text-align: center;"><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A</p> <p>If yes, has the patient responded to the initial course of Humira therapy?</p> <p style="text-align: center;"><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A</p> <p>If no, has the patient already been receiving Humira, is in remission, and is continuing therapy for maintenance of remission?</p> <p style="text-align: center;"><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A</p> <p>Is Humira being prescribed to induce remission or maintain remission?</p> <p style="text-align: center;"><input type="checkbox"/> Induce Remission <input type="checkbox"/> Maintain Remission</p> <p>If <u>Induce remission</u>, has the patient tried corticosteroids, or is currently on corticosteroids (Humira will be added to avoid increasing the dose of the corticosteroid), or are corticosteroids contraindicated in this patient?</p> <p style="text-align: center;"><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A</p>																			
<p>8. <u>If the diagnosis is Uveitis (noninfectious) in children or adults</u>, has the patient tried one of the following therapies: periocular, intraocular, or systemic corticosteroids, immunosuppressants (azathioprine, MTX, mycophenolate mofetil, cyclophosphamide, cyclosporine), Enbrel, or Remicade?</p> <p>If yes, please list therapies tried: _____</p> <p>_____</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A																

<p>9. <u>If the diagnosis is Sarcoidosis</u>, has the patient tried corticosteroids AND immunosuppressive agents (Methotrexate (MTX), azathioprine, cyclosporine, chlorambucil), Remicade, chloroquine, or thalidomide?</p> <p>If yes, please list medications tried: _____</p> <p>_____</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A										
<p>10. <u>If the diagnosis is Plaque psoriasis</u>, does the patient have plaque psoriasis of the palms, soles, head, neck, nails, genitalia, or intertriginous area?</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A										
<p>11. <u>If the diagnosis is Plaque psoriasis</u>, is the minimum body surface area (BSA) involvement with plaque psoriasis greater than or equal to 5%?</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A										
<p>12. <u>If the diagnosis is Plaque psoriasis</u>, does the patient have significant disability or impairment in physical or mental functioning, according to the treating physician?</p> <p>If yes, has the patient had an inadequate response to a 3 month trial of either topical therapy OR localized phototherapy with ultraviolet B (UVB) or oral methoxsalen plus UVA light (PUVA)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A										
<p>13. <u>If the diagnosis is Plaque psoriasis</u>, has the patient tried a systemic therapy or phototherapy for 3 months with one of the following:</p> <p>If yes, please indicate:</p> <table border="0"> <tr> <td><input type="checkbox"/> Acitretin (Soriatane)</td> <td><input type="checkbox"/> Methotrexate</td> </tr> <tr> <td><input type="checkbox"/> Alefacept (Amevive)</td> <td><input type="checkbox"/> Phototherapy with UVB or PUVA for psoriasis</td> </tr> <tr> <td><input type="checkbox"/> Cyclosporine</td> <td><input type="checkbox"/> Ustekinumab (Stelara)</td> </tr> <tr> <td><input type="checkbox"/> Etanercept (Enbrel)</td> <td><input type="checkbox"/> Other: _____</td> </tr> <tr> <td><input type="checkbox"/> Infliximab (Remicade)</td> <td>_____</td> </tr> </table>	<input type="checkbox"/> Acitretin (Soriatane)	<input type="checkbox"/> Methotrexate	<input type="checkbox"/> Alefacept (Amevive)	<input type="checkbox"/> Phototherapy with UVB or PUVA for psoriasis	<input type="checkbox"/> Cyclosporine	<input type="checkbox"/> Ustekinumab (Stelara)	<input type="checkbox"/> Etanercept (Enbrel)	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Infliximab (Remicade)	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
<input type="checkbox"/> Acitretin (Soriatane)	<input type="checkbox"/> Methotrexate												
<input type="checkbox"/> Alefacept (Amevive)	<input type="checkbox"/> Phototherapy with UVB or PUVA for psoriasis												
<input type="checkbox"/> Cyclosporine	<input type="checkbox"/> Ustekinumab (Stelara)												
<input type="checkbox"/> Etanercept (Enbrel)	<input type="checkbox"/> Other: _____												
<input type="checkbox"/> Infliximab (Remicade)	_____												
<p>14. <u>If the diagnosis is Behcet's disease</u>, has the patient tried and not responded to one conventional therapy (for example: systemic corticosteroids, immunosuppressants [azathioprine, MTX, mycophenolate mofetil, tacrolimus, chlorambucil, cyclophosphamide, cyclosporine], interferon alfa, Enbrel, or Remicade)?</p> <p>If yes, please list conventional therapy tried: _____</p> <p>_____</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A										
<p>15. <u>If the diagnosis is Pyoderma gangrenosum</u>, has the patient tried one other systemic therapy (for example: systemic corticosteroids or immunosuppressants such as azathioprine, 6-mercaptopurine, cyclosporine, cyclophosphamide, chlorambucil, Remicade, Enbrel) for at least 2 months OR a 2 month trial of an intralesional injections of corticosteroids or cyclosporine for localized pyoderma gangrenosum?</p> <p>If yes, please list: _____</p> <p>_____</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A										
<p>16. <u>If the diagnosis is Juvenile rheumatoid arthritis or Juvenile idiopathic arthritis</u>, regardless of type of onset, has the patient tried methotrexate, sulfasalazine, or leflunomide or a biologic DMARD (e.g., etanercept, abatacept, infliximab, anakinra, tocilizumab), or an NSAID, or will be starting on Humira concurrently with methotrexate, sulfasalazine, or leflunomide?</p> <p>If yes, please list: _____</p> <p>_____</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A										

<p>17. <u>If the diagnosis is Juvenile rheumatoid arthritis or Juvenile idiopathic arthritis</u>, regardless of type of onset, does the patient have an absolute contraindication to methotrexate (for example: pregnancy, breast feeding, alcoholic liver disease, immunodeficiency syndrome, bloody dyscrasias), suflasalazine, or leflunomide?</p> <p>If no, does the patient have aggressive disease as determined by the prescribing physician?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
<p>18. <u>If the diagnosis is Hidradenitis suppurativa</u>, has the patient tried one other therapy (for example: intralesional or oral corticosteroids, topical or systemic antibiotics, isotretinoin) for the current condition?</p> <p>If yes, please list: _____</p> <p>_____</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A

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

<p>Prescriber Signature: _____ Date: _____</p> <p>Office Contact Name: _____ Phone Number: _____</p>
--

Based upon each patient's prescription plan, additional questions may be required to complete the prior authorization process. If you have any questions about the process or required information, please contact our prior authorization team at the number listed on the top of this form.

Prior Authorization of Benefits is not the practice of medicine or a substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for the patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions.

The document(s) accompanying this transmission may contain confidential health information. This information is intended only for the use of the individual or entity named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you received this information in error, please notify the sender immediately and arrange for the return or destruction of the documents.