EXPRESS SCRIPTS®

Prior Authorization Form
Humira

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 **1-877-329-3760**
If this an **URGENT** request, please call 1-800-753-2851

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:

- ☐ Humira 20mg/0.4ml Syringe (Kit)
- ☐ Humira 40mg/0.8ml Crohn's Disease Starter Pen (Kit)
- ☐ Humira 40mg/0.8ml Psoriasis Starter Pen (Kit)
- ☐ Humira 40mg/0.8ml Pen (Kit)
- ☐ Humira 40mg/0.8ml Syringe (Kit)
- ☐ Other_____

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

Please complete the clinical assessment:

1. Has the patient been established on Humira for greater than or equal to 90 days?	☐ Yes	☐ No

2. What is the indication or diagnosis?

- ☐ Ankylosing spondylitis
- ☐ Behcet's disease
- ☐ Crohn's disease
- ☐ Hidradenitis suppurativa
- ☐ Juvenile rheumatoid arthritis (JRA) or Juvenile idiopathic arthritis (JIA)
- ☐ Plaque psoriasis
- ☐ Psoriatic arthritis
- ☐ Pyoderma gangrenosum
- ☐ Rheumatoid arthritis in adults
- ☐ Undifferentiated spondylarthritis (undifferentiated arthritis)
- ☐ Uveitis
- ☐ Ulcerative colitis in an Adult
- ☐ Other: _____

3. Is Humira to be given in combination with any of the following DMARDS: ☐ Actemra (tocilizumab) ☐ Cimzia (certolizumab pegol) ☐ Enbrel (etanercept) ☐ Kineret (anakinra) ☐ Methotrexate [MTX] (oral, injection) ☐ Remicade (infliximab) ☐ Orencia (abatacept) ☐ Rituxan (rituximab) ☐ Simponi (golimumab) ☐ Stelara (ustekinumab) ☐ Xeljanz (tofacitinib) ☐ Other: _____	☐ Yes	☐ No	☐ N/A
4. Has the patient tried one DMARD (brand or generic; oral or injectable) for at least 3 months? If different duration other than 3 months, please specify: _____ ☐ Actemra ☐ Arava (leflunomide) ☐ Cimzia ☐ Enbrel ☐ Kineret ☐ Methotrexate [MTX] (oral, injection) ☐ Imuran (azothiaprine) ☐ 6-mercaptopurine ☐ Orencia ☐ Plaquenil (hydroxychloroquine) ☐ Remicade ☐ Rituxan ☐ Simponi ☐ Sulfasalazine ☐ Other: _____ _____	☐ Yes	☐ No	
5. Please list prescriber or consulting prescriber's specialty: _____			
6. If the diagnosis is rheumatoid arthritis in adults, does the patient have early RA (defined as disease duration of less than 6 months) with at least one of the following features of poor prognosis: functional limitation (e.g., based on HAQ-DI score); extraarticular disease such as rheumatoid nodules, RA vascultis or Felty's syndrome; positive rheumatoid factor or anti-CCP antibodies; or bony erosions by radiograph?	☐ Yes	☐ No	☐ N/A
7. If the diagnosis is Crohn's disease in patients equal to or greater than 6 years of age, Has the patient tried corticosteroids, or is currently on corticosteroids , or are corticosteroids contraindicated in this patient?	☐ Yes	☐ No	☐ N/A
8. If the diagnosis is Crohn's disease, Has the patient had ileocolonic resection (to reduce the chance of Crohn's disease recurrence)?	☐ Yes	☐ No	☐ N/A
9. If the diagnosis is Uveitis, has the patient tried one of the following therapies: periocular, intraocular, or systemic corticosteroids, immunosuppressants (azathioprine, MTX, mycophenolate mofetil, cyclophosphamide, cyclosporine), Enbrel, or Remicade? If yes, please list therapies tried: _____ _____	☐ Yes	☐ No	☐ N/A
10. If the diagnosis is Plaque psoriasis, has the patient experienced an intolerance to a trial of at least one oral or biologic therapy for plaque psoriasis (e.g., methotrexate, cyclosporine, Soriatane, Enbrel, Remicade, or Stelara)?	☐ Yes	☐ No	☐ N/A
11. If the diagnosis is Plaque psoriasis, Does the patient have a contraindication to one oral agent for psoriasis such as methotrexate, as determined by the prescribing physician?	☐ Yes	☐ No	☐ N/A

12. If the diagnosis is Plaque psoriasis, has the patient tried a systemic therapy or phototherapy for 3 months with one of the following: If yes, please indicate: ☐ Acitretin (Soriatane) ☐ Cyclosporine ☐ Etanercept (Enbrel) ☐ Infliximab (Remicade) ☐ Methotrexate ☐ Oral methoxsalen with ultraviolet A light (PUVA) ☐ Ustekinumab (Stelara) ☐ Other: _____ _____	☐ Yes	☐ No	☐ N/A
13. If the diagnosis is Ulcerative colitis, has the patient had a 2-month trial of one systemic agent (e.g., 6-mercaptopurine, azathioprine, cyclosporine, tacrolimus, Remicade, or a corticosteroid such as prednisone or methylprednisolone) or was intolerant to one of these agents for ulcerative colitis? If yes, please list: _____ _____	☐ Yes	☐ No	☐ N/A
14. If the diagnosis is Ulcerative colitis, does the patient have pouchitis AND has tried therapy with an antibiotic (e.g., metronidazole, ciprofloxacin), probiotic, corticosteroid enema, or Rowasa (mesalamine) enema? If yes, please list: _____	☐ Yes	☐ No	☐ N/A
15. If the diagnosis is Juvenile rheumatoid arthritis or Juvenile idiopathic arthritis, has the patient tried one other agent for this condition (e.g., methotrexate, sulfasalazine, or leflunomide or a biologic DMARD (e.g., Enbrel, Orencia, Remicade, Kineret, Actemra), or an NSAID, or will be starting on Humira concurrently with methotrexate, sulfasalazine, or leflunomide? If yes, please list: _____ _____	☐ Yes	☐ No	☐ N/A
16. If the diagnosis is Juvenile rheumatoid arthritis or Juvenile idiopathic arthritis, has the patient have an absolute contraindication to methotrexate (for example: pregnancy, breast feeding, alcoholic liver disease, immunodeficiency syndrome, bloody dyscrasias), sulfasalazine, or leflunomide? If no, does the patient have aggressive disease as determined by the prescribing physician? ☐ Yes ☐ No ☐ N/A	☐ Yes	☐ No	☐ N/A
17. If the diagnosis is Hidradenitis suppurativa, has the patient tried one other therapy (for example: intralesional or oral corticosteroids, systemic antibiotics, isotretinoin) for the current condition? If yes, please list: _____ _____	☐ Yes	☐ No	☐ N/A
18. If the diagnosis is Pyoderma gangrenosum, Has the patient tried at least one conventional therapy (for example: systemic corticosteroids, immunosuppressants [azathioprine, methotrexate, mycophenolate mofetil, tacrolimus, Leukeran, cyclophosphamide, cyclosporine], interferon alfa), Enbrel, or Remicade? If yes, please list: _____	☐ Yes	☐ No	☐ N/A

19. If the diagnosis is Behcet's disease, has the patient tried at least one conventional therapy (for example: systemic corticosteroids, immunosuppressants [azathioprine, methotrexate, mycophenolate mofetil, tacrolimus, Leukeran, cyclophosphamide, cyclosporine], interferon alfa), Enbrel, or Remicade? If yes, please list: _____	☐ Yes	☐ No	☐ N/A

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

_____

_____

_____

_____

_____

Prescriber Signature: _____Date: _____

Office Contact Name: _____ Phone Number: _____

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.

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