MedStar Medicare Choice
Pharmacy Services
Phone: 855-266-0712
Fax: 855-862-6517

HUMIRA
Prior Authorization Form

□ Standard Request (72 hours) □ Expedited Request (24 hours)	If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. For expedited requests you will receive a decision within 24 hours. You cannot request an expedited coverage determination if you are requesting reimbursement for a drug you already received.

Demographics

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
DOB:	Age:	NPI#:	Specialty:
Health Plan ID#:		Phone:	Fax:
Pharmacy Name:	Pharmacy Phone:	Office Contact:	Direct Phone # or Ext:

Medication Information

Drug Requested: Humira	Strength: □ 40mg/0.8ml Pre-Filled Syringe Kit □ 40mg/0.8ml Pre-Filled Pen Kit □ 40mg/0.8ml Pre-Filled Pen Kit Psoriasis Starter □ 40mg/0.8ml Pre-Filled Pen Kit Crohns Starter □ 10mg/0.2ml Pre-Filled Syringe Kit (Pediatric) □ 20mg/0.4ml Pre-Filled Syringe Kit (Pediatric)	Directions: Quantity Dispensed:	Day Supply:
□ New medication □ Continuation of therapy	Start Date:	If this is continuation of therapy, please provide CHART DOCUMENTATION indicating the member showed improvement while on therapy.	

Clinical Information

Disease Severity:
□ Mild
□ Moderate
□ Severe

PPD (tuberculin) test:
□ Positive
□ Negative
Date:_____

Is the member currently using another TNF-blocking or biologic agent in combination with Humira? □ Yes □ No
Medication:_____

Does the member currently have evidence of infection? □ Yes □ No

Please indicate the diagnosis on the left and complete the corresponding questions.

□Rheumatoid Arthritis

OR

□Juvenile Idiopathic Arthritis

Has the member tried and failed Methotrexate with an inadeq response? □Yes □No

If no, please fill out chart with other drug trials

Please indicate if the member tried and failed any of the following

Medication	Dates on Therapy	Dose	Reason for Discontinuing
□Leflunomide			
□Sulfasalazine			
□Hydroxychlorquine			

□ Psoriatic Arthritis

Is the members disease dominant: □ Peripheral □ Axial, skin, nail, enthesitis, dactylitis

Has the member tried and failed NSAIDs (trial of 1 required for peripheral disease and 2 for axial, nail, enthesitis, dactylitis)? □Yes □No

Please indicate if the member tried and failed any of the following

Medication	Dates on Therapy	Dose	Reason for Discontinuing
□NSAIDs (please specify agent(s))			

	☐Methotrexate			
	☐ Cyclosporine			
	☐Sulfasalazine (Azulfidine)			
	☐ Leflunomide (Arava)			

☐ Ankylosing Spondylosis	Is the members disease dominant: ☐ Peripheral ☐ Axial Has the member tried and failed at least 2 NSAIDs? ☐Yes ☐No			
	Please indicate any drug trials			
	Medication	**Dates on Therapy**	**Dose**	**Reason for Discontinuing**

☐ Plaque Psoriasis	Has the member tried and failed any topical treatment? ☐Yes ☐No Does the member have psoriasis on the palms, soles, head, neck, or genitalia? ☐Yes ☐No Has the member tried and failed phototherapy or photochemotherapy? ☐Yes ☐No Please indicate body surface area (BSA) involvement: ☐Less than 5% ☐Greater than or equal to 5%			
	Please indicate if the member tried and failed any of the following			
	Medication	**Dates on Therapy**	**Dose**	**Reason for Discontinuing**
	☐Topical:_____			
	☐Methotrexate			
	☐ Cyclosporine			
	☐ Acitretin			

☐ Crohn's Disease *OR* ☐ Ulcerative Colitis	Has the member tried and failed corticosteroids? ☐Yes ☐No			
	Please indicate if the member tried and failed any of the following			
	Medication	**Dates on Therapy**	**Dose**	**Reason for Discontinuing**
	☐5-ASA (mesalamine, balsalazide, olsalazine, sulfasalazine – please specify agent(s))			
	☐Immunosuppressant (please specify agent)			
	☐Other (please specify)			

☐ Hidradentitis suppurativa (HS)	Does the member have moderate or severe disease (with 3 active abscesses, inflammatory nodules, or lesions)? ☐Yes ☐No

Please provide any additional information which should be considered in the space below: