HUMIRA (ADALIMUMAB) [PREFERRED] PRIOR AUTHORIZATION FORM

(form effective 1/3/2022)

Keystone First | PERFORMRX℠ Next Generation Pharmacy Benefits

Fax to PerformRx℠ at **1-866-497-1387**, or to speak to a representative call **1-800-588-6767**.

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.
   ☐ screened for hepatitis B (anti-HBs, HBsAg, and anti-HBc) ☐ screened for tuberculosis

2. All diagnoses: Is Humira being prescribed by or in consultation with an appropriate specialist?
   ☐ Yes – *List specialty:*_____ ☐ No

3. Ankylosing spondylitis: Does the patient have a history of trial and failure of a two-week trial of continuous treatment with two different oral NSAIDs?
   ☐ Yes – *List medications tried:* _____ ☐ No

4. Crohn's disease: Does at least one of the following apply to the patient?
   ☐ moderate to severe Crohn's disease and one of the following:
   ☐ failed to achieve remission with or has a contraindication or intolerance to an induction course of corticosteroids
   ☐ failed to maintain remission or has a contraindication or intolerance to immunomodulators
   ☐ has one or more high-risk or poor prognostic features
   ☐ has achieved remission with the requested medication and will be using the requested medication as maintenance therapy to maintain remission

5. Ulcerative colitis: Check all that apply to the patient.
   ☐ mild UC that is associated with multiple poor prognostic factors
   ☐ moderate-to-severe UC
   ☐ failed to achieve remission with or has a contraindication or intolerance to an induction course of corticosteroids
   ☐ failed to maintain remission or has a contraindication or intolerance to immunomodulators
   ☐ has achieved remission with the requested medication and will be using the requested medication as maintenance therapy to maintain remission

6. 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 non-biologic DMARD?
   ☐ Yes – *List medications tried:* _____ ☐ No

7. Juvenile idiopathic arthritis (JIA): Check all that apply to the patient.
   ☐ therapeutic failure of a three-month trial of a conventional non-biologic DMARD; list medications tried: _____
   ☐ contraindication or intolerance to non-biologic DMARDs; provide explanation: _____
   ☐ systemic JIA with active systemic features
   ☐ one or more risk factors for disease severity
   ☐ involvement of high-risk joints (e.g., cervical spine, hip, wrist)
   ☐ high disease activity
   ☐ is at high risk of disabling joint damage
   ☐ active sacroiliitis and/or enthesitis and has tried and failed a two-week trial of an oral NSAID; list medications tried: _____

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

8. Psoriatic arthritis: Does at least one of the following apply to the patient?
   - ☐ axial disease and/or enthesitis
   - ☐ peripheral disease and has tried and failed methotrexate or other DMARD; list medications tried:
   - ☐ severe disease
   - ☐ concomitant moderate-to-severe nail disease

9. Moderate to severe chronic psoriasis: Check all that apply to the patient.
   - ☐ at least 3% of body surface area (BSA) is affected
   - ☐ critical areas of the body are involved (such as face, palms, soles, and/or genitals)
   - ☐ significant disability or impairment of physical or mental functioning
   - ☐ moderate to severe nail disease
   - ☐ history of therapeutic failure, contraindication or intolerance to:
     - ☐ topical corticosteroids or other topical therapy; list medications tried or explain contraindication:_____
     - ☐ 3-month trial of oral systemic therapy; list medications tried or explain contraindication:_____
     - ☐ ultraviolet light therapy

10. 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:_____

11. Hidradenitis suppurative (HS): Check all that apply to the patient.
    - ☐ Hurley stage II disease
    - ☐ Hurley stage III disease
    - ☐ history of therapeutic failure, contraindication, or intolerance to:
      - ☐ 3-month trial of topical clindamycin
      - ☐ adequate trial of a systemic antibiotic
    - ☐ Is a candidate for or has history of surgical intervention for HS

12. All other diagnoses: Submit documentation supporting the use of Humira for the patient's diagnosis and other treatments tried.

RENEWAL REQUESTS

1. . Since starting Humira, has the patient experienced improvement in disease activity and/or level of functioning?
   ☐ Yes ☐ No
2. Is Humira being prescribed by or in consultation with an appropriate specialist?
   - ☐ Yes - list specialty: _____
   - ☐ No

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date: