



Humira (Adalimumab) Prior Authorization Request Form



Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

URGENT

MEMBER INFORMATION		
LAST NAME:	FIRST NAME:	
PHONE NUMBER:	DATE OF BIRTH:	
STREET ADDRESS:		
CITY:	STATE:	ZIP CODE:
PATIENT INSURANCE ID NUMBER:		

MALE FEMALE HEIGHT (IN/CM): _____ WEIGHT (LB/KG): _____ ALLERGIES: _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: [HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF](https://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF)

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
 AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION		
LAST NAME:	FIRST NAME:	
PRESCRIBER SPECIALTY:	EMAIL ADDRESS:	
NPI NUMBER:	DEA NUMBER:	
PHONE NUMBER:	FAX NUMBER:	
STREET ADDRESS:		
CITY:	STATE:	ZIP CODE:
REQUESTOR (if different than prescriber):	OFFICE CONTACT PERSON:	

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:
<input type="checkbox"/> NEW THERAPY <input type="checkbox"/> RENEWAL		IF RENEWAL: DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page.





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MEMBER'S LAST NAME: _____ MEMBER'S FIRST NAME: _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? <input type="checkbox"/> YES (if yes, complete below) <input type="checkbox"/> NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE): 	DURATION OF THERAPY (SPECIFY DATES): 	RESPONSE/REASON FOR FAILURE/ALLERGY:
2. LIST DIAGNOSES:		ICD-10:
<input type="checkbox"/> Ankylosing spondylitis <input type="checkbox"/> Crohn's disease <input type="checkbox"/> Hidradenitis suppurativa <input type="checkbox"/> Juvenile idiopathic arthritis (JIA) <input type="checkbox"/> Non-infectious uveitis <input type="checkbox"/> Plaque psoriasis <input type="checkbox"/> Psoriatic arthritis <input type="checkbox"/> Pyoderma gangrenosum <input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Ulcerative colitis <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____		
3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.		
Clinical Information: Will Humira be used in combination with another biologic response modifier [such as Kineret (anakinra), Rituxan (rituximab), Remicade (infliximab), Orencia (abatacept), Cimzia (certolizumab pegol), Enbrel (etanercept), Simponi (golimumab), Actemra (tocilizumab)] or Xeljanz (tofacitinib)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Select if the requested medication is prescribed by the following specialist: <input type="checkbox"/> Dermatologist <input type="checkbox"/> Gastroenterologist <input type="checkbox"/> Ophthalmologist <input type="checkbox"/> Rheumatologist		
For ankylosing spondylitis, also answer the following: Has the patient had adequate trial and failure to at least TWO (2) non-steroidal anti-inflammatory agents (NSAIDs)? <input type="checkbox"/> Yes <input type="checkbox"/> No Please document the two NSAIDs tried: _____		
Are non-steroidal anti-inflammatory agents (NSAIDs) contraindicated in this patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Has the patient had a trial of methotrexate? <input type="checkbox"/> Yes <input type="checkbox"/> No		
For Crohn's disease, also answer the following: Select if the patient has had a trial of the following:* <input type="checkbox"/> 5-ASA/mesalamine <input type="checkbox"/> 6-mercaptopurine <input type="checkbox"/> Azathioprine		





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Glucocorticoid therapy

Methotrexate

**Please provide supporting chart notes for verification*

Is there clinical rationale explaining why the patient cannot try glucocorticoid therapy, methotrexate, azathioprine, 6-mercaptopurine or 5-ASA/mesalamine?* Yes No

**Please provide supporting documentation.*

For **hidradenitis suppurativa**, also answer the following:

Is the medication being used prior to surgery? Yes No

For **juvenile idiopathic arthritis (JIA)**, also answer the following:

Has the patient had a trial and inadequate response to therapy with oral disease modifying anti-rheumatic agents (DMARDs) [e.g., methotrexate, azathioprine (Imuran), auranofin (Ridaura), hydroxychloroquine (Plaquenil), sulfasalazine (Azulfidine), leflunomide (Arava)]? Yes No

**Please submit chart documentation on therapies the patient has tried.*

Does the patient have chronic liver disease such as chronic alcohol abuse/alcoholism, chronic hepatitis, fatty liver, nonalcoholic steatohepatitis/NASH, or elevated liverenzymes? Yes No

Is there clinical rationale explaining why the patient cannot try a DMARD?* Yes No

**Please provide supporting documentation.*

For **non-infectious uveitis**, also answer the following:

Does the patient have isolated anterior uveitis? Yes No

For **plaque psoriasis**, also answer the following:

Does the patient have plaques covering at least 3% of their body surface area (BSA) or < 3% of BSA, but with involvement of palms, soles, head and neck, or genitalia which causes disruption of normal activities? Yes No

Select if patient has had previous treatment failure with any of the following:

- | | |
|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Acitretin | <input type="checkbox"/> Methotrexate |
| <input type="checkbox"/> Cyclosporine | <input type="checkbox"/> Phototherapy |

**Please submit what therapies the patient has tried.*

Is there clinical rationale explaining why the patient cannot try any of the following: methotrexate, cyclosporine, acitretin, or phototherapy?* Yes No

**Please provide supporting documentation.*

For **psoriatic arthritis**, also answer the following:

Has the patient had a trial and inadequate response to therapy with oral disease modifying anti-rheumatic agents (DMARDs) [e.g., methotrexate, azathioprine (Imuran), auranofin (Ridaura), hydroxychloroquine (Plaquenil), penicillamine (Cuprimine), sulfasalazine (Azulfidine), leflunomide (Arava)]?* Yes No

**Please submit chart documentation on therapies the patient has tried.*

Does the patient have chronic liver disease such as chronic hepatitis, fatty liver, nonalcoholic steatohepatitis/NASH, or elevated liverenzymes? Yes No





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Is there clinical rationale explaining why the patient cannot try a DMARD? Yes No

**Please provide supporting documentation*

For pyoderma gangrenosum, also answer the following:

Has the patient had a trial of glucocorticoid therapy? Yes No

Please provide supporting chart notes.

Select if the patient has had a trial of the following systemic therapies:

- Azathioprine Dapsone Nicotine
- Chlorambucil Hyperbaric oxygen Tacrolimus
- Cyclophosphamide Intravenous immune globulin Thalidomide
- Cyclosporine Mycophenolate

Is there clinical rationale explaining why the patient cannot try corticosteroids and one additional systemic therapy (such as cyclosporine, mycophenolate, dapsone, azathioprine, etc.)? Yes No

**Please provide supporting documentation.*

For rheumatoid arthritis, also answer the following:

Has the patient had a trial with methotrexate or another oral disease modifying anti-rheumatic agent (DMARD) such as azathioprine (Imuran), auranofin (Ridaura), hydroxychloroquine (Plaquenil), sulfasalazine (Azulfidine), or leflunomide (Arava)? Yes No

**Please submit chart documentation on therapies the patient has tried.*

Does the patient have chronic liver disease such as chronic alcohol abuse/alcoholism chronic hepatitis, fatty liver, nonalcoholic steatohepatitis/NASH, or elevated liver enzymes? Yes No

Is the patient unable to take a non-biologic DMARD due to patient is a male of fatherhood potential or a female of childbearing potential? Yes No

If "no" to the above question, provide the rationale explaining why the patient cannot take the prerequisite non-biologic DMARDs: _____

For ulcerative colitis, also answer the following:

Select if the patient has tried and failed at least one of the following therapies:

- Corticosteroids
- Azathioprine
- 6-mercaptopurine

**Please provide supporting chart notes.*

Is there clinical rationale explaining why the patient cannot try corticosteroids, azathioprine, or 6-mercaptopurine? Yes No

**Please provide supporting documentation.*

Reauthorization:

If this is a reauthorization request, answer the following questions:

Select if the requested medication is prescribed by the following specialist:

- Dermatologist
- Gastroenterologist





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- Ophthalmologist
- Rheumatologist

For all indications except non-infectious uveitis, also answer the following:

Is the patient continuing to have a positive clinical response and remission of disease with continued use of Humira? * Yes No

**Please provide documentation supporting this information.*

For non-infectious uveitis, also answer the following:

Has the patient 's response been evaluated at a recent office visit (i.e., occurring after previous date of approval)?*

- Yes No

**Please provide progress notes/chart notes from the patient's ophthalmologist or rheumatologist supporting this information.*

Has the patient had a positive response to therapy? Yes No

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: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

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FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program; c/o Magellan Health, Inc.
 4801 E. Washington Street, Phoenix, AZ 85034
 Phone: 877-228-7909

