FUTURE SCRIPTS Secure

Please complete ALL information below and fax your request to 1-888-671-5285

Humira® Coverage Determination Request Form (Page 1 of 2)

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Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:	Office Contact:	
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name: Select one of the following: ❑ Request is for **GENERIC** ❑ Request is for **BRAND** (unable to take the generic)	Strength:	Dosage Form:
❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the Type(s) of Coverage Determination Requested:

❑ **Prior Authorization**- Request is for a drug that requires prior authorization under the plan.

❑ **Quantity Limit**- Request is for an exception to the plan's quantity limit.
Quantity requested: _____

Select the diagnosis below:

❑ Ankylosing spondylitis (AS)
❑ Crohn's disease (CD)
❑ Hidradenitis suppurativa
❑ Moderate-to-severe juvenile idiopathic arthritis (JIA)
❑ Moderate to severe plaque psoriasis
❑ Moderate-to-severe rheumatoid arthritis
❑ Non-infectious intermediate, posterior, or pan-uveitis
❑ Psoriatic arthritis (PsA)
❑ Ulcerative colitis
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Is there documentation the patient has been evaluated for active or latent tuberculosis (TB)? ❑ **Yes** ❑ **No**

Will the patient receive Humira concurrently with any other biologic disease modifying anti-rheumatic drugs (DMARDs) (e.g., tumor necrosis factor antagonists)? ❑ **Yes** ❑ **No**

Select if Humira is prescribed by one of the following specialists:

❑ Dermatologist ❑ Ophthalmologist
❑ Gastroenterologist ❑ Rheumatologist

For new starts only: Have at least two weeks passed since the administration of the Herpes Zoster vaccine prior to the start of therapy? ❑ **Yes** ❑ **No**

For ankylosing spondylitis, juvenile idiopathic arthritis, psoriatic arthritis, or rheumatoid arthritis, also answer the following:

Select if there is documentation the patient has had an inadequate response or inability to tolerate the following:

❑ Azathioprine ❑ Leflunomide ❑ Remicade (infliximab)
❑ Hydroxychloroquine ❑ Methotrexate ❑ Sulfasalazine

For Crohn's disease or ulcerative colitis, also answer the following:

Select if there is documentation the patient has had an inadequate response or inability to tolerate the following:

❑ Aminosalicylate
❑ Corticosteroids
❑ Immunomodulators (e.g., azathioprine, 6-mercaptopurine)
❑ Remicade (infliximab)

Humira® Coverage Determination Request Form (Page 2 of 2)

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For hidradenitis suppurativa, also answer the following:

Is there documentation the patient has had an inadequate response or inability to tolerate Remicade (infliximab)? ❑ **Yes** ❑ **No**

For non-infectious intermediate, posterior, or pan-uveitis, also answer the following:

Select if there is documentation the patient has had an inadequate response or inability to tolerate the following:

- ❑ One oral corticosteroid
- ❑ One topical ophthalmic steroid
- ❑ Remicade (infliximab)

For plaque psoriasis, also answer the following:

Select if there is documentation the patient has had an inadequate response or inability to tolerate the following:

- ❑ Remicade (infliximab)
- ❑ Topical anthralin
- ❑ Topical calcipotriene containing products
- ❑ Topical immunomodulators (Elidel, Protopic)
- ❑ Topical retinoids
- ❑ Topical steroids

Quantity Limit Requests:

Is there a high risk of significant adverse clinical outcome with medication change or dosage change? ❑ **Yes** ❑ **No**

Is the requested quantity and dose within FDA approved maximum dosing limits or supported by peer-reviewed medical literature, accepted standards of medical practice and/or medical compendia? ❑ **Yes** ❑ **No**

If **yes,** please specify:_____

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: This request may be denied unless all required information is received.