FUTURE SCRIPTS

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

Humira® Prior Authorization 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:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the diagnosis below:

- ❑ Active ankylosing spondylitis
- ❑ Active psoriatic arthritis
- ❑ Moderate to severe chronic plaque psoriasis
- ❑ Moderate to severe hidradenitis suppurativa (i.e., Hurley Stage II or III)
- ❑ Moderately to severely active Crohn's disease
- ❑ Moderately to severely active polyarticular juvenile idiopathic arthritis (JIA)
- ❑ Moderately to severely active rheumatoid arthritis (RA)
- ❑ Moderately to severely active ulcerative colitis
- ❑ Uveitis (UV)
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Prescriber's Specialty:

Select if Humira is prescribed by or in consultation with one of the following specialists:

❑ Dermatologist ❑ Gastroenterologist ❑ Ophthalmologist ❑ Rheumatologist

For active ankylosing spondylitis, answer the following:

Has the patient had trial and failure, contraindication, or intolerance to two non-steroidal anti-inflammatory drugs (NSAIDs)? ❑ **Yes** ❑ **No**

For moderately to severely active Crohn's disease, answer the following:

Select if the patient has had trial and failure, contraindication, or intolerance to the following conventional therapies:

- ❑ 6-mercaptopurine (Purinethol)
- ❑ Azathioprine (Imuran)
- ❑ Corticosteroids (e.g., prednisone, methylprednisolone)
- ❑ Methotrexate (Rheumatrex, Trexall)

Has the patient had trial and failure (i.e., lost response) or intolerance to Remicade (infliximab)? ❑ **Yes** ❑ **No**

For moderately to severely active polyarticular juvenile idiopathic arthritis (JIA), answer the following:

Select if the patient has had trial and failure, contraindication, or intolerance to the following non-biologic disease modifying anti-rheumatic drugs (DMARDs):

- ❑ Arava (leflunomide)
- ❑ Methotrexate (Rheumatrex/Trexall)

For moderately to severely active rheumatoid arthritis, answer the following:

Has the patient had trial and failure, contraindication, or intolerance to one non-biologic disease modifying anti-rheumatic drug (DMARD) (e.g., methotrexate [Rheumatrex/Trexall], leflunomide [Arava], sulfasalazine [Azulfidine])? ❑ **Yes** ❑ **No**

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For moderately to severely active ulcerative colitis, answer the following:

Select if the patient has had trial and failure, contraindication, or intolerance to the following conventional therapies:

- ❑ 6-mercaptopurine (Purinethol)
- ❑ Aminosalicylate (e.g., mesalamine [Asacol, Pentasa, Rowasa], olsalazine [Dipentum], sulfasalazine [Azulfidine, Sulfazine])
- ❑ Azathioprine (Imuran)
- ❑ Corticosteroids (e.g., prednisone, methylprednisolone)

For uveitis (UV), answer the following:

Does the patient have non-infectious uveitis? ❑ **Yes** ❑ **No**

Select the classification of uveitis:

- ❑ Intermediate
- ❑ Posterior
- ❑ Panuveitis

Reauthorization:

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

Is there documentation the patient has had a positive clinical response to Humira therapy? ❑ **Yes** ❑ **No**

For moderately to severely active ulcerative colitis, also answer the following:

For patients who initiated Humira therapy within the past 12 weeks, is there documentation the patient has had clinical remission or significant clinical benefit by eight weeks (Day 57) of therapy? ❑ **Yes** ❑ **No**

For patients who have been maintained on Humira therapy for longer than 12 weeks, is there documentation the patient has had a positive clinical response to Humira 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?

_____

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