

Fax completed form to: 1-866-868-0858
Questions, please call: 1-866-316-6049

GENERATIONS HEALTHCARE

Important Information About Prescription Drug Coverage

To: _____ From: _____

Fax: _____ Pages: _____

Re: Humira® (adalimumab): Prior Authorization Request Form: Please respond.

- Please complete the attached Humira® (adalimumab) Prior Authorization Request Form
- To expedite the review process please complete all requested fields.
- Completed forms should be faxed to: 1-866-868-0858. It is not necessary to fax this cover page.

Please note: By signing the attached form you are certifying that the treatment requested is medically necessary. No contraindications are present and precautions have been considered. You will be supervising the patient's treatment. Supporting documentation is available in the patient's record. Signature on this form attests to the fact that the corresponding ICD-9 code has been documented in the patients chart and submitted on a CMS- 1500 form.

Information about this drug

Humira® (adalimumab)

The frequency of serious infection and malignancy among Humira®-treated subjects > 65 years of age in clinical trials was higher than for those younger than 65 years of age. Please consider one of the following DMARD alternatives in treating rheumatoid arthritis, ankylosing spondylitis, and psoriatic arthritis if clinically appropriate: azathioprine, hydroxychloroquine, methotrexate, sulfasalazine, leflunomide, gold (Auranofin®), or penicillamine. In the treatment of Crohn's disease, Humira® should be reserved for patients with refractory disease, glucocorticoid dependant, or unresponsive to primary therapy.

You can make an expedited request by indicating this at the top of the attached form. If you request an expedited review, and sign the attached form, you certify that applying the 72 hour standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Information on the attached form is protected health information and subject to all privacy and security regulations under HIPAA.

Prior Authorization Request Form

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Patient Information

Name _____
Member ID _____
Medicare ID _____
Date of birth _____ Sex: M / F
Address _____
City _____
State _____ ZIP _____
Phone _____
Nursing home resident? YES / NO
Home care patient? YES / NO

Prescriber and Pharmacy Information

Name _____
Specialty _____
DEA _____
NPI _____
Address _____
City _____
State _____ ZIP _____
Phone _____ Fax _____
Pharmacy name _____
NCPDP _____
NPI _____
Phone _____ Fax _____

All items below this line are for Physician Use Only

Information for Requested Drug

Strength: _____ Dosage form: _____ Qty per 30 days: _____ Drug is (circle one): Newly prescribed/Refill
Directions: _____ Diagnosis: _____ ICD-9 Code: _____

Standard Reviews will be completed in under 72 hours. An expedited review is available if you certify that a standard review timeframe will seriously jeopardize the health of your patient. To request an expedited review, simply indicate this at the top of this page.

Humira® (adalimumab) Criteria

- 1 Please indicate Humira®'s dispensing location:
 the pharmacy
 the physician's supply incident to a physician's visit
 other: _____
- 2 Specify the patient's diagnosis:
 Rheumatoid Arthritis
 Juvenile Rheumatoid Arthritis
 Crohn's Disease
 Ankylosing spondylitis
 Other: _____
 Psoriatic Arthritis
- 3 Please specify the diagnosis code(s) supporting the necessity for the requested agent. This question must be completed.
 ICD-9 _____
- 4 Is the prescribing physician a rheumatologist, gastroenterologist or has one been consulted?
 Yes No
- 5 Does the patient have any of the following exclusion criteria (check all that apply)?
 Yes No
 Active infection (e.g., chronic leg ulcers, recurrent respiratory infections, indwelling catheter, TB, hepatitis B/C, HIV)
- Septic arthritis of a native joint within the last 12 months
- Sepsis of a prosthetic joint within the last 12 months or indefinitely if the joint remains in situ
- NYHA Class 3 or 4 heart failure
- Clear history of demyelinating disease
- 6 If the patient has rheumatoid arthritis, ankylosing spondylitis or psoriatic arthropathy, has the patient failed to receive a clinically appropriate therapeutic response over at least 3 months OR demonstrated intolerance (e.g., allergy, hypersensitivity, adverse effect(s), development of a contraindication) from either methotrexate OR two (2) or more alternate DMARDs (e.g., azathioprine, sulfasalazine, hydroxychloroquine, leflunomide, Ridaura®, penicillamine) over a period of 30 or more days for each drug?
 Yes No
- 7 If the patient's diagnosis is Crohn's Disease, have they failed to receive a clinically appropriate therapeutic response OR demonstrated intolerance (e.g., allergy, hypersensitivity, adverse effects, development of a contraindication) from either: Glucocorticoids, azathioprine, 6- mercaptopurine or methotrexate

Medical justification: (Attach additional page if necessary): _____

Prescriber's signature: _____ Date: _____