

Fax completed form to: 1-866-868-0858

Questions, please call: 1-866-316-6049



SELECTCARE of TEXAS, L.L.C.

## Important Information About Prescription Drug Coverage

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To: \_\_\_\_\_ From: \_\_\_\_\_

Fax: \_\_\_\_\_ Pages: \_\_\_\_\_

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

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- 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

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#### 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.**

MemberHealth, LLC, PO Box 391197, Solon OH 44139-3911

Last Updated: 03/13/2008

M0018\_PATEMP\_1107 CMS 11/28/07 H4506

# Prior Authorization Request Form

Fax completed form to 1-866-868-0858 Need help? Call 1-866-316-6049



## 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: \_\_\_\_\_