

HUMIRA (adalimumab)

SPECIALTY PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Three separate Specialty Pharmacy Prior Authorization Request forms are included in this document:

- Form 1 - Humira used for the treatment of Crohn's Disease
- Form 2 - Humira used for the treatment of Psoriasis
- Form 3 - Humira used for the treatment of Rheumatoid Arthritis and related conditions

Prescribers (or their designees) should complete the form most applicable to the patient's diagnosis or reason for treatment. Providers may call Caremark at 1-866-814-5506 with any questions concerning prior authorization procedures. On behalf of the member's health plan, Caremark assists in the administration of the prior authorization program. Caremark is an independent company that administers prescription drug benefits.

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SPECIALTY PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Form 1 - Humira used for the treatment of Crohn's Disease

Patient Information

Name:	Member ID #:
Group Name:	Date of Birth:
Diagnosis:	Diagnosis Code:

Provider Information

Prescriber's Name:	Prescriber's DEA #:
Phone:	Fax:
Office Address:	

Complete and review information, sign and date. Fax signed form to Caremark Specialty's prior authorization department at 1-866-249-6155. The Caremark fax machine is located in a secure location as required by HIPAA regulations. On behalf of the member's health plan, Caremark assists in the administration of the prior authorization program. Caremark is an independent company that administers prescription drug benefits.

Providers may call Caremark at 1-866-814-5506 with any questions concerning prior authorization procedures. For questions related to the patient's eligibility, drug copay or delivery, providers and members should call Caremark Specialty Customer Care at 1-866-513-5214 with any questions. Members may also call their health plan at the number indicated on their Member ID cards.

Please check or circle the appropriate answer for each applicable question (Y for Yes, N for No).

1. What drug is being prescribed? Humira
2. **Is prescribed drug being used as a single Biologic Response Modifier** (e.g. Amevive, Cimzia, Enbrel, Humira, Raptiva, Remicade)? Y N
3. What is the **primary** diagnosis? Adult Rheumatoid Arthritis Juvenile Rheumatoid Arthritis
 Psoriatic Arthritis Ankylosing Spondylitis Crohn's Disease Psoriasis
 Ulcerative Colitis Reactive Arthritis Pyoderma gangrenosum Wegener's granulomatosis
 Inflammatory Bowel Disease Arthritis Myelosclerosis with myeloid metaplasia Behcet's disease
 Hidradenitis suppurativa Other (specify): _____

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4. Has the patient been tested for latent Tuberculosis (TB)? Y N
5. Was the TB test Positive or Negative? Positive Negative
- [If the answer is negative, skip to question 8.]
6. If positive, has active Tuberculosis (TB) been ruled out? Y N
7. If TB has been ruled out, has antibiotic prophylaxis for latent TB been initiated? Y N
8. Is patient at risk for Hepatitis B Virus (HBV) infection? Y N
9. Has Hepatitis B been ruled out or treatment initiated? Y N
10. Does patient have other active infection (chronic or localized)? Y N
11. Does patient have pre-existing or recent onset demyelinating disease (e.g., Multiple Sclerosis)? Y N
12. Does patient have unstable moderate to severe Congestive Heart Failure (CHF)? Y N
13. Is patient currently on therapy with the Biologic Response Modifier being prescribed (Humira)? Y N
- [If the answer is yes, may skip to question 18.]
14. Has patient tried and had inadequate response to conventional therapy? Y N

Please document previous treatment regimen.

- Sulfasalazine (Azulfidine, Sulfazine) Mesalamine, oral (Asacol, Pentasa) Prednisone
- Metronidazole (Flagyl) Azathioprine (Azasan, Imuran) Mercaptopurine (Purinethol)
- Methotrexate Hydrocortisone, IV (Solu-Cortef) Cyclosporine, IV (Sandimmune)
- Remicade Other (specify): _____

15. If patient has not tried and failed conventional therapy, is there a clinical reason to avoid conventional therapy as initial treatments and start biologic therapy at this time? Y N N/A

If yes, please document the reason: _____

16. What is the anticipated infusion date? _____

Answer the question below only if patient is currently receiving Cimzia, Humira or Remicade.

17. Is the patient experiencing a response to current biologic therapy? Y N

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18. If the patient is not experiencing a response to current biologic therapy, is there a clinical reason for the lack of efficacy? Y N N/A

If yes, please document the reason: _____

Comments:

I affirm that the information given on this form is accurate as of this date.

Prescriber (or Authorized) Signature and Date::

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Form 2 - Humira used for the treatment of Psoriasis

Patient Information

Name:	Member ID #:
Group Name:	Date of Birth:
Diagnosis:	Diagnosis Code:

Provider Information

Prescriber's Name:	Prescriber's DEA #:
Phone:	Fax:
Office Address:	

Complete and review information, sign and date. Fax signed form to Caremark Specialty's prior authorization department at 1-866-249-6155. The Caremark fax machine is located in a secure location as required by HIPAA regulations. On behalf of the member's health plan, Caremark assists in the administration of the prior authorization program. Caremark is an independent company that administers prescription drug benefits.

Providers may call Caremark at 1-866-814-5506 with any questions concerning prior authorization procedures. For questions related to the patient's eligibility, drug copay or delivery, providers and members should call Caremark Specialty Customer Care at 1-866-513-5214 with any questions. Members may also call their health plan at the number indicated on their Member ID cards.

Please check or circle the appropriate answer for each applicable question (Y for Yes, N for No).

1. What drug is being prescribed?
2. **Is prescribed drug being used as a single Biologic Response Modifier** (e.g. Amevive, Enbrel, Humira, Raptiva, Remicade)? Y N
3. What is the **primary** diagnosis? Adult Rheumatoid Arthritis Juvenile Rheumatoid Arthritis
 Psoriatic Arthritis Ankylosing Spondylitis Crohn's Disease Psoriasis
 Ulcerative Colitis Reactive Arthritis Pyoderma gangrenosum Wegener's granulomatosis
 Inflammatory Bowel Disease Arthritis Myelosclerosis with myeloid metaplasia Behcet's disease
 Hidradenitis suppurativa Other (specify): _____

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4. Has the patient been tested for latent Tuberculosis (TB)? Y N
5. Was the TB test Positive or Negative? Positive Negative
- [If the answer is negative, may skip to question 8.]
6. If positive, has active Tuberculosis (TB) been ruled out? Y N
7. If TB has been ruled out, has antibiotic prophylaxis for latent TB been initiated? Y N
8. Is patient at risk for Hepatitis B Virus (HBV) infection? Y N
9. Has Hepatitis B been ruled out or treatment initiated? Y N
10. Does patient have other active infection (chronic or localized)? Y N
11. Does patient have pre-existing or recent onset demyelinating disease (e.g., Multiple Sclerosis)? Y N
12. Does patient have unstable moderate to severe Congestive Heart Failure (CHF)? Y N
13. What is the affected % Body Surface Area (BSA)? _____
14. What is the affected area of the body?
- Hands Feet Face Neck Groin Other (specify): _____
15. Is patient currently on therapy with a Biologic Response Modifier (Amevive, Enbrel, Humira, Raptiva or Remicade)? Y N
- [If the answer is yes, skip to question 24.]
16. Does the psoriasis cause disruption of daily activities? Y N
17. Has patient tried or had an insufficient response to topical therapy? Y N
18. Has patient tried or had an insufficient response to phototherapy? Y N
19. Has patient tried or had an insufficient response to systemic therapy? Y N
- If yes, which agents were tried and had insufficient response? _____
20. Was patient compliant with the prescribed treatments? Y N
21. Has dose/route been optimized without adequate response? Y N
22. Is there a clinical reason to avoid these therapies (phototherapy/systemic) as initial treatments? Y N
- If yes, what is the reason? _____

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Answer the question below only if patient is currently receiving Amevive, Enbrel, Humira, Raptiva or Remicade.

23. Is the prescribed medication the same as the Biologic Response Modifier (BRM) that the patient is currently on? Y N

If yes, has the patient's psoriasis improved? Y N

If the patient's psoriasis has not improved, what is the reason for the lack of improvement? _____

What is the current Body Surface Area? _____%

If the patient's psoriasis has not improved, please document current BRM and length of therapy. _____

Will current BRM be discontinued? Y N

Comments: _____

I affirm that the information given on this form is accurate as of this date.

Prescriber (or Authorized) Signature and Date::

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SPECIALTY PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Form 3 - Humira used for the treatment of Rheumatoid Arthritis and related conditions

Patient Information	
Name:	Member ID #:
Group Name:	Date of Birth:
Diagnosis:	Diagnosis Code:

Provider Information	
Prescriber's Name:	Prescriber's DEA #:
Phone:	Fax:
Office Address:	

Complete and review information, sign and date. Fax signed form to Caremark Specialty's prior authorization department at 1-866-249-6155. The Caremark fax machine is located in a secure location as required by HIPAA regulations. On behalf of the member's health plan, Caremark assists in the administration of the prior authorization program. Caremark is an independent company that administers prescription drug benefits.

Providers may call Caremark at 1-866-814-5506 with any questions concerning prior authorization procedures. For questions related to the patient's eligibility, drug copay or delivery, providers and members should call Caremark Specialty Customer Care at 1-866-513-5214 with any questions. Members may also call their health plan at the number indicated on their Member ID cards.

Please check or circle the appropriate answer for each applicable question (Y for Yes, N for No).

1. What drug is being prescribed?
2. **Is prescribed drug being used as a single Biologic Response Modifier** (e.g. Amevive, Cimzia, Enbrel, Humira, Kineret, Orencia, Raptiva, Remicade, Rituxan)? Y N
3. What is the **primary** diagnosis? Adult Rheumatoid Arthritis Juvenile Rheumatoid Arthritis
 Psoriatic Arthritis Ankylosing Spondylitis Crohn's Disease Psoriasis
 Ulcerative Colitis Reactive Arthritis Pyoderma gangrenosum Wegener's granulomatosis
 Inflammatory Bowel Disease Arthritis Myelosclerosis with myeloid metaplasia Behcet's disease
 Hidradenitis suppurativa Other (specify): _____

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4. Has the patient been tested for latent Tuberculosis (TB)? Y N

5. Was the TB test Positive or Negative? Positive Negative

[If the answer is negative, skip to question 8.]

6. If positive, has active Tuberculosis (TB) been ruled out? Y N

7. If TB has been ruled out, has antibiotic prophylaxis for latent TB been initiated? Y N

8. Is patient at risk for Hepatitis B Virus (HBV) infection? Y N

9. Has Hepatitis B been ruled out or treatment initiated? Y N

10. Does patient have other active infection (chronic or localized)? Y N

11. Does patient have pre-existing or recent onset demyelinating disease (e.g., Multiple Sclerosis)? Y N

12. Does patient have unstable moderate to severe Congestive Heart Failure (CHF)? Y N

13. Is patient currently on therapy with the Biologic Response Modifier being prescribed (Enbrel, Humira, Kineret, Orencia, Remicade or Rituxan)? Y N

[If the answer is yes, may skip to question 18.]

Has patient tried or had an insufficient response to synthetic Disease Modifying Anti-Rheumatic Drug (DMARD)? Y N

If no, please document clinical reason for not trying a DMARD. _____

If yes, please document the DMARD and the length of therapy that the patient has tried or had insufficient response to: _____

14. Was patient compliant with therapy? Y N

15. Has dose/route been optimized without adequate response? Y N

Answer the question below only if patient is currently receiving Enbrel, Humira, Kineret, Orencia, Remicade or Rituxan.

16. Is the prescribed medication the same as the Biologic Response Modifier (BRM) that the patient is currently on? Y N

If the prescribed medication the same as the BRM that the patient is currently on, has the patient's RA improved? Y N

If no, what is the reason for the lack of improvement? _____

If the prescribed medication is not the same as the BRM that the patient is currently on, please document current BRM and length of therapy. _____

Will current BRM be discontinued? Y N

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Answer the question below only if patient is currently receiving Enbrel, Humira, Kineret, Orencia, Remicade or Rituxan.

17. Is the prescribed medication the same as the Biologic Response Modifier (BRM) that the patient is currently on? Y N

If the prescribed medication is the same as the BRM that the patient is currently on, has the patient's RA improved? Y N

If no, what is the reason for the lack of improvement? _____

If the prescribed medication is not the same as the BRM that the patient is currently on, please document current BRM and length of therapy. _____

Will current BRM be discontinued? Y N

Comments:

I affirm that the information given on this form is accurate as of this date.

Prescriber (or Authorized) Signature and Date::