

PHYSICIAN PRIOR AUTHORIZATION REQUEST FORM BlueCross BlueShield of South Carolina

Patient Information	
Name:	Insurance ID #:
Group #:	Birthdate:

Provider Information	
Physician's Name:	Physician DEA #:
Phone:	Fax:
Office Address:	
Diagnosis:	ICD-9 Code:

When this form is completed, please fax to Caremark at 1-888-836-0730.

This fax machine is located in a HIPAA-compliant, secure location. On behalf of BlueCross BlueShield of South Carolina, Caremark assists in the administration of prescription drug programs. Caremark is an independent company that provides pharmacy benefits management.

Call Caremark at 1-800-294-5979 with any questions concerning prior authorization procedures.

1. Is the physician purchasing and providing the drug "incident to" physician services?

Note: Check guidelines at this point. If PA meets the Close As D scenario, continue with clinical questions. If not, no more questions are required and Close As B.

 Y N

2. Is the patient 18 years of age or older?

[If the answer to this question is no, may skip to question 15.]

 Y N

3. At the initiation of therapy, did the patient have a diagnosis of moderately or severely active rheumatoid arthritis as the reason for requesting Humira?

[If the answer to this question is yes, may skip to question 16.]

 Y N

4. At the initiation of therapy, did the patient have the diagnosis of active psoriatic arthritis as the reason for requesting Humira?

[If the answer to this question is yes, may skip to question 19.]

 Y N

5. At the initiation of therapy, did the patient have a diagnosis of active ankylosing spondylitis as the reason for requesting Humira?

[If the answer to this question is no, may skip to question 9.]

 Y N

6. Has the patient had an inadequate response to at least two non-steroidal anti-inflammatory drugs (NSAIDs), or has an intolerance to multiple NSAID drugs?

 Y N

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7. Does the patient have predominantly peripheral arthritis symptoms?
[If the answer to this question is no, may skip to question 19.] Y N
8. If indicated, did the patient have an inadequate response, or has an intolerance to or a contraindication to sulfasalazine?
[May skip to question 19.] Y N
9. At the initiation of therapy, did the patient have a diagnosis of moderately to severely active Crohn's disease as the reason for requesting Humira?
[If the answer to this question is no, may skip to question 12.] Y N
10. Has the patient received Humira as a Caremark benefit for at least 6 months and has demonstrated reduced signs and symptoms or achieved clinical remission of the Crohn's disease?
[If the answer to this question is yes, may skip to question 22.] Y N
11. Did the patient have an inadequate response to conventional therapy for Crohn's disease (i.e., prednisone, budesonide, sulfasalazine (Azulfidine), azathioprine (Imuran), mesalamine (Asacol or Pentasa) or infliximab (Remicade)?
[If the answer to this question is yes, may skip to question 19.] Y N
12. At the initiation of therapy, did the patient have a diagnosis of chronic moderate to severe plaque psoriasis as the reason for requesting Humira?
[If the answer to this question is no, may skip to question 15.] Y N
13. Is the patient a candidate for systemic therapy or phototherapy? Y N
14. Is systemic therapy or phototherapy medically less appropriate or contraindicated for the patient?
[May skip to question 19.] Y N
15. At the initiation of therapy, did the patient have the diagnosis of moderately to severely active polyarticular (with multiple joint involvement) juvenile idiopathic arthritis (JIA, also referred to as juvenile rheumatoid arthritis) as the reason for requesting Humira?
[If the answer to this question is no, no further questions required.] Y N
16. Has the patient tried and had an inadequate response to at least one or more disease-modifying antirheumatic drugs (DMARDs) or does the patient have an intolerance or contraindication to multiple DMARDs?
[e.g., methotrexate (MTX), Imuran (azathioprine), Ridaura (oral gold), Plaquenil (hydroxychloroquine), Cuprimine (D-penicillamine), Azulfidine (sulfasalazine), Arava (leflunomide)] Y N
17. Is the patient currently receiving, or has in the past received, Humira therapy through a Caremark administered benefit?
[If the answer to this question is no, may skip to question 19.] Y N
18. Have the arthritis symptoms of the patient improved since the initiation of therapy?
[If the answer to this question is yes, may skip to question 22.] Y N
19. At the initiation of therapy, was the patient evaluated for latent tuberculosis infection with a PPD test? Y N
20. At the initiation of therapy, did the patient have a positive PPD tuberculosis test as defined by a greater than or equal to 5 mm of induration?
[If the answer to this question is no, may skip to question 22.] Y N
21. Has the patient completed treatment for latent tuberculosis or has the patient started and is planning to complete treatment for latent tuberculosis? Y N
22. Does the patient have an active infection?
[If the answer to this question is yes, no further questions required.]

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23. Is the patient receiving a biologic response modifier, either a tumor necrosis factor (TNF) blocking agents [e.g. Kineret] other than Humira?

[If the answer to this question is no, may skip to question 25.]

Y N

24. Will the biologic response modifier be discontinued?

[If the answer to this question is no, no further questions required.]

Y N

25. Has the prescriber assessed the patient's risk of hepatitis B, and if appropriate, tested for hepatitis B?

Y N

Comments: _____

Information on this form is accurate as of the date below.

Prescriber's Signature: 	Date:
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