US Family Health Plan
Prior Authorization Request Form for
adalimumab **(Humira)**

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be **faxed** to **617-562-5296**

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Step 1 **Please complete patient and physician information** (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

1. Is the patient 18 years of age or older?	☐ Yes proceed to question **7 on page 2**	☐ No proceed to question **2**
2. What is the indication or diagnosis in this pediatric patient?	☐ moderate to severe active polyarticular **juvenile idiopathic arthritis** – proceed to question **3** ☐ moderately to severely active **Crohn's disease** – proceed to question **4** ☐ Uveitis – proceed to question **5** ☐ other indication or diagnosis – **STOP: Coverage not approved.** **Please document diagnosis:** _____	
3. Is the patient 2 to 17 years of age? (that is, age 2 through 17 years)	☐ Yes proceed to question **10 on page 2**	☐ No **STOP** **Coverage not approved**
4. Is the patient 6 years of age or older?	☐ Yes proceed to question **6**	☐ No **STOP** **Coverage not approved**
5. Is the patient 2 years of age or older?	☐ Yes proceed to question **10 on page 2**	☐ No **STOP** **Coverage not approved**
6. Has the patient had an inadequate response to corticosteroids, azathioprine, 6-mercaptopurine (6-MP), or methotrexate?	☐ Yes proceed to question **10 on page 2**	☐ No **STOP** **Coverage not approved**

Questions 6 – 11 continue on next page

7.	**What is the indication or diagnosis in this adult patient?**	☐ moderately to severely active **rheumatoid arthritis** – go to question **10** ☐ active **psoriatic arthritis** – go to question **10** ☐ active **ankylosing spondylitis** – go to question **8** ☐ moderate to severe **chronic plaque psoriasis** in a patient who may benefit from taking injection or pills (systemic therapy) or phototherapy – go to question **10** ☐ moderately to severely active **Crohn's disease** – go to question **9** ☐ moderately to severely active **ulcerative colitis** – go to question **10** ☐ hidradenitis suppurativa – go to question **10** ☐ treatment of **uveitis** (non-infectious intermediate, posterior and panuveitis patients)– go to question **10** ☐ other indication or diagnosis – **STOP: Coverage not approved.** **Please document diagnosis:** _____	
8.	**Has the patient had an inadequate response to at least two NSAIDS over a period of at least two months?**	☐ Yes – to go question **10**	☐ No – **STOP** **Coverage not approved**
9.	**Has the patient had an inadequate response to conventional therapy?** *(for example, methotrexate, aminosalicylates [e.g. sulfasalazine, mesalamine], corticosteroids, immunosuppressants [e.g. azathioprine], etc.)*	☐ Yes – go to question **10**	☐ No – **STOP** **Coverage not approved**
10.	**Cases of worsening congestive heart failure (CHF) and new onset CHF have been reported with TNF blockers, including HUMIRA. Is the prescriber aware of this?**	☐ Yes – go to question **11**	☐ No – **STOP** **Coverage not approved**
11.	**Will the patient be receiving other targeted immunomodulatory biologics with Humira, including but not limited to the following: Actemra, Cimzia, Cosentyx, Enbrel, Ilumya, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Rituxan, Siliq, Simponi, Stelara, Taltz, Tremfya or Xeljanz/Xeljanz XR?**	☐ Yes – **STOP** **Coverage not approved**	☐ No – go to question **12**
12.	**Has the patient had evidence of a negative TB test result in the past 12 months (or TB is adequately managed)?**	☐ Yes – **Sign and date below**	☐ No – **Sign and date below**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____

Prescriber Signature Date