USFHP Prior Authorization Request Form for adalimumab **(preferred brand 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 855-273-5735

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

https://www.usfamilyhealth.org/for-providers/pharmacy-information/

When prescribed by a rheumatologist, dermatologist, or gastroenterologist a prior authorization is not required. Prior authorization is required when prescribed in other situations.

Note that the PA applies to the branded Humira formulation by Abbvie. The Cordavis brand is completely excluded from the TRICARE benefit.

Prior authorization does not expire. Clinical documentation may be required.

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 medication being prescribed by or in consultation with a rheumatologist, dermatologist, gastroenterologist or pulmonologist?	☐ Yes proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Is the patient 18 years of age or older?	☐ Yes proceed to question **5**	☐ No proceed to question **3**
3. Is the patient 2 years of age or older?	☐ Yes proceed to question **4**	☐ No **STOP** **Coverage not approved**

4. What is the indication or diagnosis in this pediatric patient?	☐ Moderate to severe active **polyarticular idiopathic arthritis (JIA), including subtypes** - proceed to question **8** ☐ Treatment of **uveitis** (non-infectious intermediate, posterior and panuveitis patients) – proceed to question **8** ☐ Moderately to severely active **Crohn's disease** – proceed to question **9** ☐ Moderate to severe **hidradenitis suppurativa** – proceed to question **8** ☐ **Moderate to severe plaque psoriasis** in patients who are candidates for systemic or phototherapy– proceed to question **9** ☐ Moderately to severely active **ulcerative colitis** – proceed to question **9** ☐ Generalized pustular psoriasis (GPP) – proceed to question **7** ☐ Refractory sarcoidosis – proceed to question **8** ☐ Other indication or diagnosis – proceed to question **10**

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5.	**What is the indication or diagnosis in this adult patient?**	☐ Moderately to severely active **rheumatoid arthritis** – proceed to question **8** ☐ Active **psoriatic arthritis** – proceed to question **9** ☐ Active **ankylosing spondylitis** – proceed to question **6** ☐ Active **non-radiographic axial spondyloarthritis (nr-ax SpA)** with objective signs of inflammation – proceed to question **6** ☐ Moderate to severe **chronic plaque psoriasis** in patients who are candidates for systemic therapy or phototherapy – proceed to question **8** ☐ Moderately to severely active **Crohn's disease** – proceed to question **9** ☐ Moderately to severely active **ulcerative colitis** – proceed to question **9** ☐ Moderate to severe **hidradenitis suppurativa** – proceed to question **8** ☐ Treatment of **uveitis** (non-infectious intermediate, posterior and panuveitis patients)– proceed to question **8** ☐ Moderately to severely active **pyoderma gangrenosum (PG)** that is refractory to high-potency corticosteroids– proceed to question **8** ☐ Generalized pustular psoriasis (GPP) – proceed to question **7** ☐ Refractory sarcoidosis – proceed to question **8** ☐ Other indication or diagnosis – proceed to question **10**	
6.	**Has the patient had an inadequate response to at least two NSAIDS over a period of at least two months?**	☐ Yes proceed to question **9**	☐ No **STOP** **Coverage not approved**
7.	**Does the patient have a history of at least two Generalized pustular psoriasis (GPP) flares of moderate-to-severe intensity in the past?**	☐ Yes proceed to question **8**	☐ No **STOP** **Coverage not approved**
8.	**Has the patient had an inadequate response, intolerance, or contraindication to non-biologic systemic therapy, antibiotics or anti-androgens? (for example: methotrexate, aminosalicylates [such as, sulfasalazine, mesalamine], corticosteroids, immunosuppressants [for example, azathioprine], etc.)?**	☐ Yes proceed to question **9**	☐ No **STOP** **Coverage not approved**
9.	**Will the patient be receiving other targeted immunomodulatory biologics (TIBs) with Humira, including but not limited to the following: TNF inhibitors, IL-1, IL-6, IL-17, IL-23, IL-36, JAK inhibitors?**	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

10. Please provide the diagnosis and rationale for treatment. Supportive evidence will be considered.	_____ **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