

# 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 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**

Medical documentation may be required. Failure to provide could result in denial.

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

<b>1</b>	Patient Name: _____	Physician Name: _____
	Address: _____	Address: _____
	Sponsor ID #: _____	Phone #: _____
	Date of Birth: _____	Secure Fax #: _____

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

<b>2</b>	<p><b>1. Is the patient 18 years of age or older?</b></p> <p style="text-align: center;"><input type="checkbox"/> Yes proceed to question <b>9</b></p> <p style="text-align: center;"><input type="checkbox"/> No proceed to question <b>2</b></p> <p><b>2. What is the indication or diagnosis in this pediatric patient?</b></p> <p><input type="checkbox"/> moderate to severe active <b>polyarticular juvenile idiopathic arthritis (pJIA)</b> - proceed to question <b>3</b></p> <p><input type="checkbox"/> treatment of <b>uveitis</b> (non-infectious intermediate, posterior and panuveitis patients) - proceed to question <b>3</b></p> <p><input type="checkbox"/> moderately to severely active <b>Crohn's disease</b> – proceed to question <b>5</b></p> <p><input type="checkbox"/> <b>hidradenitis suppurativa</b> – go to question <b>6</b></p> <p><input type="checkbox"/> <b>Severe chronic plaque psoriasis</b> in patients who are candidates for systemic or phototherapy, and when other systemic therapies are medically less appropriate (4-17 years) – go to question <b>8</b></p> <p><input type="checkbox"/> moderately to severely active <b>ulcerative colitis</b> – go to question <b>4</b></p> <p><input type="checkbox"/> Other indication or diagnosis – <b>STOP</b>: Coverage not approved.</p> <p><b>Please document diagnosis:</b> _____</p>	
	<p><b>3. Is the patient 2 years of age or older?</b></p> <p style="text-align: center;"><input type="checkbox"/> Yes proceed to question <b>13</b></p> <p style="text-align: center;"><input type="checkbox"/> No <b>STOP</b> Coverage not approved</p>	
	<p><b>4. Is the patient 5 years of age or older?</b></p> <p style="text-align: center;"><input type="checkbox"/> Yes proceed to question <b>8</b></p> <p style="text-align: center;"><input type="checkbox"/> No <b>STOP</b> Coverage not approved</p>	
	<p><b>5. Is the patient 6 years of age or older?</b></p> <p style="text-align: center;"><input type="checkbox"/> Yes proceed to question <b>7</b></p> <p style="text-align: center;"><input type="checkbox"/> No <b>STOP</b> Coverage not approved</p>	
	<p><b>6. Is the patient 12 years of age or older?</b></p> <p style="text-align: center;"><input type="checkbox"/> Yes proceed to question <b>13</b></p> <p style="text-align: center;"><input type="checkbox"/> No <b>STOP</b> Coverage not approved</p>	

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7. Does the patient have fistulizing CD?	<input type="checkbox"/> Yes proceed to question 13	<input type="checkbox"/> No proceed to question 8
8. Has the patient had an inadequate response to non-biologic systemic therapy? (For example: methotrexate, aminosalicylates [e.g. sulfasalazine, mesalamine], corticosteroids, immunosuppressants [e.g. azathioprine], etc.)?	<input type="checkbox"/> Yes proceed to question 13	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
9. What is the indication or diagnosis in this adult patient?	<input type="checkbox"/> moderately to severely active <b>rheumatoid arthritis</b> –go to question 12 <input type="checkbox"/> active <b>psoriatic arthritis</b> –go to question 13 <input type="checkbox"/> <b>Ankylosing spondylitis</b> – go to question 10 <input type="checkbox"/> Active non-radiographic axial spondyloarthritis (nr-ax SpA) with objective signs of inflammation – go to question 12 <input type="checkbox"/> moderate to severe <b>chronic plaque psoriasis</b> in a patient who may benefit from taking injection or pills (systemic therapy) or phototherapy – go to question 12 <input type="checkbox"/> moderately to severely active <b>Crohn’s disease</b> –go to question 11 <input type="checkbox"/> moderately to severely active <b>ulcerative colitis</b> – go to question 12 <input type="checkbox"/> <b>hidradenitis suppurativa</b> –go to question 13 <input type="checkbox"/> treatment of <b>uveitis</b> (non-infectious intermediate, posterior and panuveitis patients)– go to question 12 <input type="checkbox"/> moderately to severely active <b>pyoderma gangrenosum (PG)</b> that is refractory to high-potency corticosteroids– go to question 13 <input type="checkbox"/> Other indication or diagnosis – <b>STOP: Coverage not approved.</b> <b>Please document diagnosis:</b> _____	
10. Has the patient had an inadequate response to at least two NSAIDs over a period of at least two months?	<input type="checkbox"/> Yes proceed to question 13	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
11. Does the patient have fistulizing CD?	<input type="checkbox"/> Yes proceed to question 13	<input type="checkbox"/> No proceed to question 12
12. Has the patient had an inadequate response to non-biologic systemic therapy? (For example: methotrexate, aminosalicylates [such as, sulfasalazine, mesalamine], corticosteroids, immunosuppressants [such as, azathioprine], etc.)?	<input type="checkbox"/> Yes proceed to question 13	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
13. 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?	<input type="checkbox"/> Yes proceed to question 14	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
14. Has the patient had evidence of a negative TB test result in the past 12 months (or TB is adequately managed)?	<input type="checkbox"/> Yes proceed to question 15	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
15. Will the patient be receiving other targeted immunomodulatory biologics with Humira, including but not limited to the following: certolizumab (Cimzia), etanercept (Enbrel), golimumab (Simponi), infliximab (Remicade), apremilast (Otezla), ustekinumab (Stelara), abatacept (Orencia), anakinra (Kineret), tocilizumab (Actemra), tofacitinib (Xeljanz/Xeljanz XR), rituximab (Rituxan), secukinumab (Cosentyx), ixekizumab (Taltz), brodalumab (Siliq), sarilumab (Kevzara), guselkumab (Tremfya), baricitinib (Olumiant), tildrakizumab (Ilumya), risankizumab (Skyrizi), or upadacitinib (Rinvoq ER)?	<input type="checkbox"/> Yes <b>STOP</b> Coverage not approved	<input type="checkbox"/> No <b>Sign and date below</b>

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

\_\_\_\_\_ Prescriber Signature

\_\_\_\_\_ Date