US Family Health Plan

Prior Authorization Request Form for

Adalimumab (Humira excludes Cordavis brand)

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**

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 USFHP benefit.

Prior authorization does not expire.

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 a rheumatologist, dermatologist, or gastroenterologist?	☐ Yes **Sign and date below**	☐ No proceed to question **2**
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 **9** ☐ Treatment of **uveitis** (non-infectious intermediate, posterior and panuveitis patients) – proceed to question **9** ☐ Moderately to severely active **Crohn's disease** – proceed to question **10** ☐ Moderate to severe **hidradenitis suppurativa** – proceed to question **9** ☐ **Moderate to severe plaque psoriasis** in patients who are candidates for systemic or phototherapy– proceed to question **10** ☐ Moderately to severely active **ulcerative colitis** – proceed to question **9** ☐ Generalized pustular psoriasis (GPP) – proceed to question **8** ☐ Other indication or diagnosis – **STOP**: Coverage not approved.

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5.	**What is the indication or diagnosis in this adult patient?**	☐ Moderately to severely active **rheumatoid arthritis** – proceed to question **9** ☐ Active **psoriatic arthritis** – proceed to question **10** ☐ 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 **9** ☐ Moderately to severely active **Crohn's disease** – proceed to question **7** ☐ Moderately to severely active **ulcerative colitis** – proceed to question **9** ☐ Moderate to severe **hidradenitis suppurativa** – proceed to question **9** ☐ Treatment of **uveitis** (non-infectious intermediate, posterior and panuveitis patients)– proceed to question **9** ☐ Moderately to severely active **pyoderma gangrenosum (PG)** that is refractory to high-potency corticosteroids– proceed to question **9** ☐ Generalized pustular psoriasis (GPP) – proceed to question **8** ☐ Other indication or diagnosis – **STOP: Coverage not approved.**	
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 **10**	☐ No **STOP** **Coverage not approved**
7.	**Does the patient have fistulizing CD?**	☐ Yes proceed to question **10**	☐ No proceed to question **8**
8.	**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 **9**	☐ No **STOP** **Coverage not approved**
9.	**Has the patient had an inadequate response to non-biologic systemic therapy, antibiotics or anti-androgens? (For example: methotrexate, aminosalicylates [such as, sulfasalazine, mesalamine], corticosteroids, immunosuppressants [such as, azathioprine], etc.)?**	☐ Yes proceed to question **10**	☐ No **STOP** **Coverage not approved**
10.	**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, apremilast (Otezla), ustekinumab (Stelara), abatacept (Orencia), anakinra (Kineret), tocilizumab, tofacitinib (Xeljanz/Xeljanz XR), rituximab , secukinumab (Cosentyx), ixekizumab (Taltz), brodalumab (Siliq), sarilumab (Kevzara), guselkumab (Tremfya), baricitinib (Olumiant), tildrakizumab (Ilumya), risankizumab (Skyrizi), or upadacitinib (Rinvoq ER)?**	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

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

Prescriber Signature Date

[26 November 2024]