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.
When prescribed by a rheumatologist, prior authorization is not required. Prior authorization is required when prescribed in other situations.
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?	☐ Yes **Sign and date below**	☐ No proceed to question **2**
2. Is the patient 18 years of age or older?	☐ Yes proceed to question **9**	☐ No proceed to question **3**
3. What is the indication or diagnosis in this pediatric patient?	☐ moderate to severe active **polyarticular juvenile idiopathic arthritis (pJIA)** - proceed to question **4** ☐ treatment of **uveitis** (non-infectious intermediate, posterior and panuveitis patients) - proceed to question **4** ☐ moderately to severely active **Crohn's disease** – proceed to question **6** ☐ **hidradenitis suppurativa** – go to question **7** ☐ **Severe chronic plaque psoriasis** in patients who are candidates for systemic or phototherapy**,** and when other systemic therapies are medically less appropriate (4-17 years) – go to question **8** ☐ moderately to severely active **ulcerative colitis** – go to question **5** ☐ Other indication or diagnosis – **STOP**: Coverage not approved. **Please document diagnosis:** _____	
4. Is the patient 2 years of age or older?	☐ Yes proceed to question **13**	☐ No **STOP** **Coverage not approved**
5. Is the patient 5 years of age or older?	☐ Yes proceed to question **8**	☐ No **STOP** **Coverage not approved**

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6. Is the patient 6 years of age or older?	☐ Yes proceed to question **13**	☐ No **STOP** **Coverage not approved**
7. Is the patient 12 years of age or older?	☐ Yes proceed to question **13**	☐ No **STOP** **Coverage not approved**
8. 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.)?	☐ Yes proceed to question **13**	☐ No **STOP** **Coverage not approved**

9. What is the indication or diagnosis in this adult patient?

- ☐ moderately to severely active **rheumatoid arthritis** – go to question **12**
- ☐ active **psoriatic arthritis** – go to question **13**
- ☐ **Ankylosing spondylitis** – go to question **10**
- ☐ Active non-radiographic axial spondyloarthritis (nr-ax SpA) with objective signs of inflammation – go to question **12**
- ☐ moderate to severe **chronic plaque psoriasis** in a patient who may benefit from taking injection or pills (systemic therapy) or phototherapy – go to question **12**
- ☐ moderately to severely active **Crohn's disease** – go to question **11**
- ☐ moderately to severely active **ulcerative colitis** – go to question **12**
- ☐ **hidradenitis suppurativa** – go to question **13**
- ☐ treatment of **uveitis** (non-infectious intermediate, posterior and panuveitis patients)– go to question **12**
- ☐ moderately to severely active **pyoderma gangrenosum (PG)** that is refractory to high-potency corticosteroids– go to question **13**
- ☐ Other indication or diagnosis – **STOP: Coverage not approved.**

Please document diagnosis: _____

10. Has the patient had an inadequate response to at least two NSAIDS over a period of at least two months?	☐ Yes proceed to question **13**	☐ No **STOP** **Coverage not approved**
11. Does the patient have fistulizing CD?	☐ Yes proceed to question **13**	☐ 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.)?	☐ Yes proceed to question **13**	☐ No **STOP** **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?	☐ Yes proceed to question **14**	☐ No **STOP** **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)?	☐ Yes proceed to question **15**	☐ No **STOP** **Coverage not approved**

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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)?	☐ Yes **STOP** **Coverage not approved**	☐ 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 _____