

**Pharmacy Prior Approval Request for
Immunomodulators: Humira**

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (in days): up to 30 Days 60 Days 90 Days 120 Days 180 Days 365 Days Other _____

Clinical Information**Request for Ankylosing Spondylitis**

1. Does the beneficiary have a diagnosis of Ankylosing Spondylitis? Yes No
2. Is the beneficiary not on another injectable biologic immunomodulator? Yes No
3. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection? Yes No
4. Has the beneficiary been tested with Hep B SAG and Core Ab? Yes No
5. Has the beneficiary experienced inadequate symptom relief from treatment with at least two NSAIDS? Yes No
6. Is the beneficiary unable to receive treatment with NSAIDS due to contraindications? Yes No
7. Does the beneficiary have clinical evidence of severe or rapidly progressing disease? Yes No

Request for Crohn's Disease (Adult)

1. Does the beneficiary have a diagnosis of moderate to severe Crohn's Disease? Yes No
2. Is the beneficiary not on another injectable biologic immunomodulator? Yes No
3. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection? Yes No
4. Has the beneficiary been tested with Hep B SAG and Core Ab? Yes No

Request for Crohn's Disease (Pediatric)

1. Does the beneficiary have a diagnosis of moderate to severe Crohn's Disease? Yes No
2. Is the beneficiary not on another injectable biologic immunomodulator? Yes No
3. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection? Yes No
4. Has the beneficiary been tested with Hep B SAG and Core Ab? Yes No

Request for Polyarticular Juvenile Idiopathic Arthritis (PJIA)

1. Does the beneficiary have a diagnosis of Polyarticular Juvenile Idiopathic Arthritis? Yes No
2. Is the beneficiary not on another injectable biologic immunomodulator? Yes No
3. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection? Yes No

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4. Has the beneficiary been tested with Hep B SAG and Core Ab? **Yes** **No**
5. Has the beneficiary tried one systemic corticosteroid (e.g. prednisone, methylprednisolone) or methotrexate, leflunomide or sulfasalazine with inadequate response or is unable to take these therapies due to contraindications?
 Yes **No**
6. Does the beneficiary have PJIA subtype enthesitis related arthritis? **Yes** **No**

Request for Plaque Psoriasis (Adult)

1. Does the beneficiary have a documented definitive diagnosis of moderate-to-severe Chronic Plaque Psoriasis?
Yes **No**
2. Is the beneficiary 18 years of age or older? **Yes** **No**
3. Is the beneficiary not on another injectable biologic immunomodulator? **Yes** **No**
4. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection (not required for Otezla)? **Yes** **No**
5. Has the beneficiary been tested with Hep B SAG and Core Ab (not required for Otezla)? **Yes** **No**
6. Does the beneficiary have a body surface area (BSA) involvement of at least 3%? **Yes** **No**
7. Does the beneficiary have involvement of the palms, soles, head and neck, or genitalia, causing disruption in normal daily activities and/or employment? **Yes** **No**
8. Has the beneficiary failed to respond to, or has been unable to tolerate phototherapy and **ONE** of the following medications or beneficiary has contraindications to these treatments: Soriatane (acitretin), Methotrexate, and/or Cyclosporine? **Yes** **No**

Request for Psoriatic Arthritis

1. Does the beneficiary have a documented definitive diagnosis of Psoriatic Arthritis? **Yes** **No**
2. Is the beneficiary 18 years of age or older (OR 2 years or older for Simponi Aria)? **Yes** **No**
3. Is the beneficiary not on another injectable biologic immunomodulator? **Yes** **No**
4. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection (not required for Otezla)? **Yes** **No**
5. Has the beneficiary been tested with Hep B SAG and Core Ab (not required for Otezla)? **Yes** **No**
6. Does the beneficiary have a documented inadequate response or inability to take methotrexate? **Yes** **No**

Request for Rheumatoid Arthritis

1. Does the beneficiary have a diagnosis of Rheumatoid Arthritis? **Yes** **No**
2. Is the beneficiary not on another injectable biologic immunomodulator? **Yes** **No**
3. Has the beneficiary been considered and screened for the presence of latent tuberculosis? **Yes** **No**
4. Has the beneficiary been tested with Hep B SAG and Core Ab? **Yes** **No**
5. Has the beneficiary experienced a therapeutic failure/inadequate response with methotrexate or at least one disease modifying antirheumatic drug (e.g. leflunomide, hydroxychloroquine, minocycline, sulfasalazine)?
 Yes **No**
6. Is the beneficiary unable to receive methotrexate or disease modifying antirheumatic drug due to contraindications or intolerabilities? **Yes** **No**
7. Does the beneficiary have clinical evidence of severe or rapidly progressing disease? **Yes** **No**

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Request for Ulcerative Colitis (Adult)

1. Does the beneficiary have a diagnosis of ulcerative colitis? **Yes** **No**
2. Is the beneficiary not on another injectable biologic immunomodulator? **Yes** **No**
3. Has the beneficiary been considered and screened for the presence of latent tuberculosis? **Yes** **No**
4. Has the beneficiary been tested with Hep B SAG and Core Ab? **Yes** **No**

Request for Ulcerative Colitis (Pediatric)

1. Does the beneficiary have a diagnosis of ulcerative colitis? **Yes** **No**
2. Is the beneficiary not on another injectable biologic immunomodulator? **Yes** **No**
3. Has the beneficiary been considered and screened for the presence of latent tuberculosis? **Yes** **No**
4. Has the beneficiary been tested with Hep B SAG and Core Ab? **Yes** **No**

Request for Hidradenitis Suppurativa: (ages 12 and older)

1. Does the beneficiary have a diagnosis of Hidradenitis Suppurativa (moderate to severe)? **Yes** **No**
2. Is the beneficiary not on another injectable biologic immunomodulator? **Yes** **No**
3. Has the beneficiary been considered and screened for the presence of latent tuberculosis? **Yes** **No**
4. Has the beneficiary been tested with Hep B SAG and Core Ab? **Yes** **No**

Request for Non-infectious Intermediate Posterior Panuveitis (ages 2 and older)

1. Does the beneficiary have a diagnosis of Non-infectious Intermediate Posterior Panuveitis? **Yes** **No**
2. Is the beneficiary not on another injectable biologic immunomodulator? **Yes** **No**
3. Has the beneficiary been considered and screened for the presence of latent tuberculosis? **Yes** **No**
4. Has the beneficiary been tested with Hep B SAG and Core Ab? **Yes** **No**

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.