Advantra from Coventry Health Care

First Health Part D from Coventry Health Care

# HUMIRA™ (adalimumab) PRIOR AUTHORIZATION FORM

***Coverage Criteria:***

- **For Rheumatoid Arthritis**: Covered as monotherapy or as adjunct therapy when prescribed by a Rheumatologist; **AND** the patient has an inadequate response to methotrexate and at least one other DMARD or BRM for the appropriate treatment period, either as monotherapy or in combination; **OR** if methotrexate use is contraindicated, after failure to respond to maximum tolerated doses or experienced unacceptable toxicity to the treatment of at least two (2) other DMARDs.
- **For Psoriatic Arthritis:** Covered as monotherapy or as adjunct therapy when prescribed by a Rheumatologist; **AND** the patient has an inadequate response to methotrexate **OR** at least one other orally administered DMARD for the appropriate treatment period, either as monotherapy or in combination.
- **For Ankylosing Spondylitis:** Covered as monotherapy when prescribed by a Rheumatologist, **AND** the patient has not responded to maximum tolerated doses of at least two (2) non-steroidal anti-inflammator drugs (NSAIDSs)
- **Juvenile Idiopathic Arthritis:** Indicated for treatment of moderately to severely active polyarticular juvenile idiopathic arthritis in patients between the ages 4 and 17 years of age when prescribed by a Rheumatologist or other prescriber, **AND** the patient has an inadequate response to methotrexate alone for the appropriate treatment period, or if methotrexate is contraindicated.
- **Crohn's Disease:** Indicated for reducing signs and symptoms and inducing and maintaining clinical remission in adult patients with moderately to severely active Crohn's disease when, **AND** patient has failed to respond to at least ONE conventional therapy for an appropriate trial period; **OR** patient has lost response to or is intolerant to infliximab (Remicade) therapy
- **Plaque Psoriasis:** Covered for patients with moderate to severe chronic plaque psoriasis when the body surface area (BSA) involvement is greater then 10% OR for patients with severe psoriasis in vulnerable areas (such as hands, soles, palms, face and genital areas), BSA involvement of greater then 1-3%, AND failure of at least two (2) non-biologic therapies, such as phototherapy or systemic therapies. Failure for this policy is defined as either no improvement or worsening of plaque psoriasis

***Authorization Period:*** For plaque psoriasis: 12 weeks. For other indications: 6 months. Subsequent approvals will be for 1 year.

## PLEASE FAX COMPLETED FORM TO: (800) 639-9158

********Please note any information that is incomplete or illegible will delay the review process.********

| | |
|---|---|
| **Patient Name:** | **Member ID #** |
| ******Member Phone Number****** | |
| **Date of Request:** | **DOB:** |
| **Plan ID:** | **Benefit:** |
| **Requesting Physician:** | **DEA #** |
| **Office Phone #** | **Office Fax #** |
| **Office Address:** | |
| **Tax ID Number:** | |

***MEDICATION INFORMATION***

| | | | |
|---|---|---|---|
| **1.** | Please indicate patient's diagnosis: ☐ Moderate to severe Rheumatoid Arthritis ☐ Psoriatic Arthritis ☐ Plaque Psoriasis ☐ Crohn's Disease ☐ Ankylosing Spondylitis | | |
| **2.** | What is the requested dose and frequency of administration? | | |
| **3.** | Will the patient be taking methotrexate along with Humira™? ☐ Yes ☐ No If not, please explain why not. | | |
| **4.** | Is the prescribing physician a Rheumatologist, Gastroenterologist, or Dermatologist? ☐ Yes ☐ No *(specify):* | | |
| **5.** | Please list past treatment trials: | | |
| | MEDICATIONS USED | DATES OF TREATMENT | THERAPEUTIC OUTCOME |
| | | | |
| | | | |
| **6.** | Please submit progress notes related to request and include any additional comments: | | |

**For Urgent Requests please call (800) 551-2694**

**Visit our Websites at http://www.firsthealthpartd.com, http://www.chcadvantra.com, http://www.summithealthplan.com and http://www.vistahealthplan.com**

**This section to be used only if requesting an exception to the plan's utilization management requirements.**
**Not completing below means medical exception to the utilization requirement(s) is not needed.**

☐ I have reviewed the requirements and acknowledge that the patient does not meet the plan's specific utilization requirements. However, based upon the reason I will provide below, it is my clinical opinion that my patient should be exempt from meeting the plan's clinical coverage criteria for this medication. **Statement should include specifically which requirement is not met and why patient should be exempt from meeting this requirement.**

**(Please note any information that is incomplete or illegible will delay the review process.)**

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**Physician's Signature:**

CHCH 9088-2 (9/12)

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