



**Humira**  
(adalimumab)

**Prior Authorization Form**  
**Curascript**  
**Fax (888) 773-7386**

Last Name	First Name	Prescriber's Name	Specialty
Home Phone	Work Phone	Office Phone	Office Fax
Home Address	City	State	ZIP
Address	City	State	ZIP
SCAN ID number	Date of Birth	Est. Start Date	Office Contact
<b>For Specialty Medications Only:</b> Shipping Address (if different from home address) <input type="checkbox"/> Physician <input type="checkbox"/> Home		Special Instructions (i.e. Non-English Speaking Patient, etc.):	

Medication:	Diagnosis:
Sig:	Qty:
Refills:	ICD 9 Code:

Secondary/ Supplemental Insurance Company	Phone	Name of Insured	ID Number	Group Number
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| <b>1. Will the patient be receiving Enbrel, Kineret or Remicade in combination with Humira?</b>  |
| <b>2. Is the diagnosis or indication Moderate to Severe Active Rheumatoid Arthritis? If no continue #4</b>   |
| <b>3. Is the patient currently taking or has the patient tried and failed at least one Disease-Modifying Anti-Rheumatic Drug for the current condition (examples include methotrexate, leflunomide, azathioprine, cyclosporine, cyclophosphamide, hydroxychloroquine sulfate)?</b> |
| <b>4. Is the diagnosis or indication for the treatment of Psoriatic Arthritis? If no continue #6</b>   |
| <b>5. Is the patient currently taking or has the patient tried and failed methotrexate for the current condition? If so, please specify what dates the member was on this medication.</b>  |
| <b>6. Is the diagnosis or indication for Humira for the treatment of chronic moderately to severe plaque psoriasis? If no continue #7</b>  |
| <b>7. Is the diagnosis or indication for the treatment of moderately to severely active Crohn's disease?</b>   |
| <b>8. Is the patient currently receiving conventional therapy (aminosalicylates, corticosteroids, immunomodulators: 6-mercaptopurine, azathioprine)?</b>   |
| <b>9. Has the patient tried and failed conventional therapy agents (aminosalicylates, corticosteroids, immunomodulators: 6-mercaptopurine, azathioprine) or Remicade?</b>  |
| <b>10. Are there any other comments, diagnoses, symptoms, and/or any other information the caller feels is important to this review?</b>   |

Physician's Signature: \_\_\_\_\_ NPI/DEA #: \_\_\_\_\_ Date: \_\_\_\_\_

<u>For Internal Use Only</u>	<input type="checkbox"/> Approved <input type="checkbox"/> Denied	Reviewer's Initials _____	Decision Date _____
Comments _____			