



**Humira Crohns**  
(adalimumab)  
**Prior Authorization Form**

**Express Scripts**  
**Phone 800-417-8164**  
**Fax 877-837-5922**

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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- Is the indication for the reduction of signs and symptoms and induction/ maintenance of clinical remission in patients with moderately to severely active Crohn's disease?**
- Is the patient currently receiving conventional therapy (aminosalicylates (i.e., sulfasalazine, balsalazide (Colazal), Pentasa, Asacol, Lialda, Apriso, or mesalamine), corticosteroids, or immunomodulators: 6-mercaptopurine, azathioprine)?**
- Has the patient tried and failed at least on the following conventional therapy agents (aminosalicylates (i.e., sulfasalazine, balsalazide (Colazal), Pentasa, Asacol, Lialda, Apriso, or mesalamine) or corticosteroids or immunomodulators: 6-mercaptopurine or azathioprine) or Remicade?**
- Are there any other comments, diagnoses, symptoms, and/or any other information the caller feels is important to this review?**

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 _____	