



Humira
(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	
For Specialty Medications Only: 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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- 1. Will patient be receiving another TNF inhibitor (e.g., Enbrel, Kineret, Orencia or Remicade) in combination with Humira?**
- 2. Is the diagnosis or indication for the treatment of moderately to severely active Rheumatoid Arthritis?
If no, continue #4**
- 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)?**
- 4. Is the diagnosis or indication for the treatment of one of the following:**
 - Psoriatic Arthritis
 - Polyarticular-Course Juvenile Rheumatoid Arthritis**If no, continue #6**
- 5. Is the patient currently taking or has the patient tried and failed methotrexate for the current condition?**
- 6. Is the diagnosis or indication for the treatment: Ankylosing Spondylitis?
If no, continue #8**
- 7. Is the patient currently taking or has the patient tried and failed at least two Non-Steroidal Inflammatory Drugs (NSAIDs) for the current condition?**
- 8. Is the diagnosis or indication for the treatment of chronic moderate to severe plaque psoriasis? If no, continue to #11.**

9.	Is the patient a candidate for phototherapy (e.g. UVB, PUVA) or systemic therapy?
10.	Has the patient tried and failed traditional therapy for psoriasis, such as phototherapy (e.g. UVB, PUVA) or systemic therapy for the current condition?
11.	Is the diagnosis or indication for the treatment of moderately to severely active Crohn's disease?
12.	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)?
13.	Has the patient tried and failed conventional therapy agents (aminosalicylates (i.e., sulfasalazine, balsalazide (Colazal), Pentasa, Asacol, Lialda, Apriso, or mesalamine), corticosteroids, immunomodulators: 6-mercaptopurine, azathioprine) or Remicade?
14.	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 _____	

Notice: **Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.** Our response time for prescription drug coverage requests is 72 hours. View our formulary and Prior Authorization forms online at <http://www.scanhealthplan.com>.