



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
VH 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
---	-------	-----------------	-----------	--------------

1. Will the patient be receiving Enbrel, Kineret or Remicade in combination with Humira?
2. Is the diagnosis or indication Moderate to Severe Active Rheumatoid Arthritis? If No, continue to #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)? If so, please specify what dates the member was on any of these medications.
4. Is the diagnosis or indication for the treatment of Psoriatic Arthritis? If No, continue to #6.
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.
6. Is the diagnosis or indication for the treatment of moderately to severely active Crohn's disease?
7. Is the patient currently receiving conventional therapy (aminosalicylates, corticosteroids, immunomodulators: 6-mercaptopurine, azathioprine)? If No, continue to #8.
8. Has the patient tried and failed conventional therapy agents (aminosalicylates, corticosteroids, immunomodulators: 6-mercaptopurine, azathioprine) or Remicade? If so, please specify what dates the member was on any of these medications.
9. Are there any other comments, diagnoses, symptoms, relevant lab values, and/or additional pertinent information that you feel 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>.