



Humira Crohns
(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	
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. Is the indication of one of the following:

- a. Reduction of signs and symptoms and induction/maintenance of clinical remission in patients with moderately to severely active Crohn's disease who have had an inadequate response to conventional therapy.**
- b. Reduction of signs and symptoms and induction of clinical remission in patients with moderately to severely active Crohn's disease if they have also lost response to or are intolerant to Infliximab.**

2. 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>.