Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Humira® (adalimumab)

Phone: 215-991-4300 Fax back to: 866-240-3712

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Address:	NPI:	Promise ID:
City, State ZIP:	*Prescriber PA PROMISe ID:*	
Patient Primary Phone:	Address:	
Line of Business: □ Medicaid □ CHIP	City, State ZIP:	
	Specialty/facility name (if applicable):	

□ Expedited/Urgent

Drug Name:
Strength:
Days Supply:
Number of Refills:
Directions / SIG:

HPP's maximum approval time is 12 months but may be less depending on the drug.

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Does the patient have a diagnosis of moderate to severe active rheumatoid arthritis (RA)?

☐ Yes ☐ No

Q2. Does the patient have a diagnosis of psoriatic arthritis (PsA)?

☐ Yes ☐ No

Q3. Is the medication prescribed in consultation with a rheumatologist?

☐ Yes ☐ No

Q4. For rheumatoid arthritis (RA) or psoriatic arthritis(PsA): Has the patient failed or had an inadequate response to the trial of at least one or more DMARD OR is intolerant to DMARDs [e.g., Imuran® (azathioprine), Ridaura® (oral gold), Plaquenil® (hydroxychloroquine), Cuprimine® (D-penicillamine), Azulfidine® (sulfasalazine), methotrexate and NSAIDs]?

☐ Yes ☐ No

Q5. Is the patient greater than 2 years old and has a diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis (JIA)?

☐ Yes ☐ No

Q6. Is the medication prescribed in consultation with a rheumatologist?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q7. For moderately to severely active polyarticular-course juvenile rheumatoid arthritis (JIA) (>2 years old): Has the patient failed or had an inadequate response to the trial of one or more DMARD or is intolerant to DMARDs. [e.g., NSAIDs, Azulfudine® (sulfasalazine), methotrexate, Imuran® (azathioprine), Ridaura® (oral gold), cyclosporine, prednisone]?

☐ Yes ☐ No

Q8. Does the patient have a diagnosis of chronic moderate to severe plaque psoriasis (Ps) and is the patient a candidate for systemic therapy or phototherapy?

☐ Yes ☐ No

Q9. Is the medication prescribed in consultation with a dermatologist?

☐ Yes, for Psoriasis with greater than 10% of the body involvement. ☐ Yes, for Psoriasis with less than 10% of the body involvement.

Q10. For psoriasis (greater than 10% of the body involvement): Has the patient failed or had an inadequate response to the trial of Methotrexate OR UVB therapy (alone or in combination with other medications) OR Soriatane (requires prior authorization)?

☐ Yes ☐ No

Q11. For psoriasis (less than 10% of the body surface area involvement): Has the patient failed, had an inadequate response or unable to tolerate the following trial of Tar, 1 topical steroid (high to very high potency for body areas) AND Dovonex (for body), tacrolimus (for face and other sensistive areas)? or Anthralin ?

☐ Yes ☐ No

Q12. Does the patient have a diagnosis of active ankylosing spondylitis (AS)?

☐ Yes ☐ No

Q13. Is the medication prescribed in consultation with a rheumatologist?

☐ Yes ☐ No

Q14. For ankylosing spondylitis (AS): Has the patient failed or had an inadequate response to the trial of at least one or more DMARD or is intolerant to DMARDs [e.g., NSAIDs, Azulfudine® (sulfasalazine), methotrexate]?

☐ Yes ☐ No

Q15. Does the patient have a diagnosis of moderately to severely active Crohn's disease (Adult or Pediatric)?

☐ Yes ☐ No

Q16. Does the patient have a diagnosis of moderately to severely active ulcerative colitis (UC)?

☐ Yes ☐ No

Q17. Is the medication prescribed in consultation with a gastroenterologist?

☐ Yes ☐ No

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Q18. For Crohn's disease (CD): Has patient failed, had inadequate response or been intolerant to a trial of corticosteroids and methotrexate or azathioprine, or lost response to or been intolerant to infliximab?

☐ Yes ☐ No

Q19. For ulcerative colitis (UC): Has patient failed, had inadequate response or been intolerant to a trial of corticosteroids, azathioprine or 6-mercaptopurine (6-MP)?

☐ Yes ☐ No

Q20. Does the patient have a diagnosis of moderate to severe Hidradenitis Suppurativa (HS)/Acne Inversa (AI)? {refer to chart for staging}

☐ Yes ☐ No

Q21. Has the patient been educated and attempted to control condition with nonpharmacological interventions such as diet, smoking cessation, temperature control, antiseptic wash?

☐ Yes ☐ No

Q22. Has the patient failed, had inadequate response or been intolerant to the following with topical antibiotics (such as clindamycin) and/ or oral antibiotics (such as doxycycline, minocycline, amoxicillin-clavulanic acid, clindamycin, rifampin, dapsone) and/or Intralesional triamcinolone injections.

☐ Yes ☐ No

Q23. Has the patient been treated with TNFa inhibitors (such as infliximab, adalimumab, etanercept, ustekinumab? (Must attach documentation)

☐ Yes ☐ No

Q24. Does the patient have a diagnosis non-infectious intermediate, posterior and panuveitis?

☐ Yes ☐ No

Q25. Is the medication prescribed in consultation with an ophthalmologist?

☐ Yes ☐ No

Q26. Has patient failed had inadequate response or is intolerant to two of the following oral or topical glucocorticoids (such as prednisone, methylprednisolone, prednisolone), immunosuppressive agents (azathioprine, methotrexate, cyclosporine) , periocular or intraocular injection (such as triamcinolone)?

☐ Yes ☐ No

Q27. Has patient been evaluated for active or latent tuberculosis infection with a tuberculin skin test prior to the initiation of therapy?

☐ Yes ☐ No

Q28. Is the tuberculin skin test negative?

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Patient Name:	**Prescriber Name:**

☐ Yes	☐ No
Q29. If latent infection is diagnosed, has the patient received appropriate prophylaxis in accordance with the CDC and prevention guidelines should be instituted?	
☐ Yes	☐ No
Q30. Has the patient been evaluated for Hepatitis B (HBV)?	
☐ Yes	☐ No
Q31. Does the patient have acute hepatitis B (HBV) or have chronic hepatitis B (HBV) with Child Pugh class B or C?	
☐ Yes	☐ No
Q32. Is the patient being treated for any other active infection?	
☐ Yes	☐ No
Q33. Has patient's immunizations been brought up to date?	
☐ Yes	☐ No
Q34. Requested Duration:	
☐ 12 Months	
Q35. Additional Information:	

Prescriber Signature

Date

Updated 2018