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. Is the prescribing physician a Rheumatologist, Dermatologist, Gastroenterologist, Ophthalmologist or in consultation with one?

☐ Yes ☐ No

Q2. What is the patient's diagnosis?

☐ Moderate to severe active rheumatoid arthritis (RA).
☐ Psoriatic arthritis (PsA).
☐ Chronic moderate to severe plaque psoriasis (Ps) and a candidate for systemic therapy or phototherapy.
☐ Moderately to severely active polyarticular juvenile idiopathic arthritis (JIA) and is 2 years of age or older.
☐ Active ankylosing spondylitis (AS) in adults.
☐ Moderately to severely active Crohn's disease (CD) or Pediatric Crohn's disease (CD) and is 6 years if age and older.
☐ Moderately to severely active ulcerative colitis (UC) in adults.
☐ Hidradenitis suppurativa (HS)/acne inversa (AI) in patients 12 years of age or older.
☐ Uveitis(UV) in adults and pediatric patients 2 years of age and older.

Q3. 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

Q4. For plaque psoriasis (Ps), is there greater than 10% of the body involvement)?

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☐ Yes	☐ No
Q5. For plaque psoriasis (Ps) - greater than 10% of body surface area 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 Acitretin (requires prior authorization)?	
☐ Yes	☐ No
Q6. For plaque psoriasis (Ps) - less than 10% of the body surface area involvement: Has the patient failed or had an inadequate response to the trial of Tar, one topical steroid (high to very high potency for body), AND Dovonex (for body), tacrolimus (for face and other sensitive areas)?	
☐ Yes	☐ No
Q7. For moderately to severely active polyarticular-course juvenile idiopathic arthritis (JIA): 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, sulfasalazine, methotrexate, azathioprine, cyclosporine, prednisone]?	
☐ Yes	☐ No
Q8. 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, sulfasalazine, and methotrexate]?	
☐ Yes	☐ No
Q9. For Crohn's disease (CD) or Pediatric Crohn's disease (CD): Has patient failed or 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
Q10. For ulcerative colitis (UC): Has patient failed or had inadequate response or been intolerant to a trial of corticosteroids, azathioprine or 6-mercaptopurine (6-MP)?	
☐ Yes	☐ No
Q11. Has the patient tried/failed or lost response to or been intolerant to infliximab?	
☐ Yes	☐ No
Q12. For moderate to severe Hidradenitis Suppurativa (HS)/Acne Inversa (AI): Has patient failed, had inadequate response or been intolerant to the following with topical antibiotics (such as clindamycin), oral antibiotics (such as doxycycline, minocycline, amoxicillin-clavulanic acid, clindamycin, rifampin, and dapsone), and Intralesional triamcinolone injections?	
☐ Yes	☐ No
Q13. For Uveitis (UV): Has patient failed, had inadequate response or been intolerant to one or more of the following oral or topical glucocorticoids (such as prednisone, methylprednisolone, and prednisolone), immunosuppressive agents (methotrexate, azathioprine, and cyclosporine) or periocular or intraocular injection (such as triamcinolone)?	
☐ Yes	☐ No

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Patient Name:	**Prescriber Name:**

Q14. Has patient been evaluated for active or latent tuberculosis infection with a tuberculin skin test prior to the initiation of therapy?

☐ Yes ☐ No

Q15. Is the tuberculin skin test negative?

☐ Yes ☐ No

Q16. If latent infection is diagnosed, has the patient received appropriate prophylaxis in accordance with the CDC and prevention guidelines should be instituted?

☐ Yes ☐ No

Q17. Is the patient being treated for any other active infection?

☐ Yes ☐ No

Q18. Requested Duration:

☐ 12 Months

Q19. Additional Information:

Prescriber Signature

Date

Updated 2018