



Prior Authorization Form

**Arkansas Blue Cross and Blue Shield (Medicare)
Medi-Pak Rx (PDP) and Medi-Pak Advantage (PFFS)
Humira (Medicare Determination)**

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS|Caremark at 1-888-836-0730.
Please contact CVS|Caremark at 1-800-294-5979 with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Humira (Medicare Determination).

Drug Name (select from list of drugs shown)
Humira (adalimumab)

Patient Information

Patient
Name: _____
Patient ID: _____
Patient
Group No.: _____
Patient
DOB: _____

Prescribing Physician

Physician
Name: _____
Physician
Phone: _____
Physician
Fax: _____
Physician
Address: _____
City, State,
Zip: _____

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each applicable question.

- | | | |
|---|---|---|
| 1. Is the physician purchasing and providing the drug "incident to" physician services? | Y | N |
| 2. Is the patient 18 years of age or older?
[If the answer to this question is no, may skip to question 13.] | Y | N |
| 3. At the initiation of therapy, did the patient have a diagnosis of moderately or severely active rheumatoid arthritis as the reason for requesting Humira?
[If the answer to this question is yes, may skip to question 14.] | Y | N |
| 4. At the initiation of therapy, did the patient have the diagnosis of active psoriatic arthritis as the reason for requesting Humira?
[If the answer to this question is yes, may skip to question 15.] | Y | N |
| 5. At the initiation of therapy, did the patient have a diagnosis of active ankylosing spondylitis as the reason for requesting Humira?
[If the answer to this question is no, may skip to question 9.] | Y | N |
| 6. Has the patient had an inadequate response to at least two non-steroidal anti-inflammatory drugs (NSAIDs), or has an intolerance to multiple NSAID drugs? | Y | N |



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| 7. | Does the patient have predominantly peripheral arthritis symptoms?
[If the answer to this question is no, may skip to question 15.] | Y | N |
| 8. | If indicated, did the patient have an inadequate response, or has an intolerance to or a contraindication to sulfasalazine?
[May skip to question 15.] | Y | N |
| 9. | At the initiation of therapy, did the patient have a diagnosis of moderately to severely active Crohn's disease as the reason for requesting Humira?
[If the answer to this question is no, may skip to question 12.] | Y | N |
| 10. | Has the patient received Humira as a Caremark benefit for at least 6 months and has demonstrated reduced signs and symptoms or achieved clinical remission of the Crohn's disease?
[If the answer to this question is yes, may skip to question 20.] | Y | N |
| 11. | Did the patient have an inadequate response to conventional therapy for Crohn's disease (i.e., prednisone, budesonide, sulfasalazine (Azulfidine), azathioprine (Imuran), mesalamine (Asacol or Pentasa) or infliximab (Remicade)?
[If the answer to this question is yes, may skip to question 16.] | Y | N |
| 12. | At the initiation of therapy, did the patient have a diagnosis of chronic moderate to severe plaque psoriasis (sufficiently severe to consider systemic therapy or phototherapy) as the reason for requesting Humira?
[If the answer to this question is yes, may skip to question 15.] | Y | N |
| 13. | At the initiation of therapy, did the patient have the diagnosis of moderately to severely active polyarticular (with multiple joint involvement) juvenile idiopathic arthritis (JIA, also referred to as juvenile rheumatoid arthritis (JRA)) as the reason for requesting Humira?
[If the answer to this question is no, no further questions required.] | Y | N |
| 14. | Has the patient tried and had an inadequate response to at least one or more disease-modifying antirheumatic drugs (DMARDs) [e.g., methotrexate (MTX), Imuran (azathioprine), Ridaura (oral gold), Plaquenil (hydroxychloroquine), Cuprimine (D-penicillamine), Azulfidine (sulfasalazine), Arava (leflunomide)], or does the patient have an intolerance or contraindication to multiple DMARDs? | Y | N |
| 15. | Is the patient currently receiving, or has in the past received, Humira therapy through a Caremark administered benefit?
[If the answer to this question is yes, may skip to question 20.] | Y | N |
| 16. | Was the presence of latent tuberculosis ruled out (i.e., TB skin testing, etc.) prior to initiation of this drug? | Y | N |
| 17. | Does the patient have an active infection?
[If the answer to this question is yes, no further questions required.] | Y | N |
| 18. | Is the patient receiving a biologic response modifier, such as tumor necrosis factor (TNF) blocking agent other than Humira [e.g., Cimzia, Enbrel, Remicade], selective co-stimulation modulator (e.g., Orencia), interleukin-1 (IL-1) receptor antagonist [e.g., Kineret] or monoclonal antibody to B cells (e.g., Rituxan)?
[If the answer to this question is no, may skip to question 20.] | Y | N |
| 19. | Will the biologic response modifier be discontinued?
[If the answer to this question is no, no further questions required.] | Y | N |
| 20. | Has the prescriber assessed the patient's risk of hepatitis B, and if appropriate, tested for hepatitis B? | Y | N |

Comments:



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I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date