

**Humira**  
**Prior Authorization Request**

**Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155**

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155.** If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506**. For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

**Patient's Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Patient's ID:** \_\_\_\_\_ **Patient's Date of Birth:** \_\_\_\_\_  
**Physician's Name:** \_\_\_\_\_  
**Specialty:** \_\_\_\_\_ **NPI#:** \_\_\_\_\_  
**Physician Office Telephone:** \_\_\_\_\_ **Physician Office Fax:** \_\_\_\_\_  
**Request Initiated For:** \_\_\_\_\_

1. Has the patient been diagnosed with any of the following?
 

<input type="checkbox"/> Moderately to severely active rheumatoid arthritis (RA)	<input type="checkbox"/> Active ankylosing spondylitis (AS)
<input type="checkbox"/> Moderate to severe chronic plaque psoriasis	<input type="checkbox"/> Active axial spondyloarthritis
<input type="checkbox"/> Moderately to severely active Crohn's disease (CD)	<input type="checkbox"/> Active polyarticular juvenile idiopathic arthritis (pJIA)
<input type="checkbox"/> Moderately to severely active ulcerative colitis (UC)	<input type="checkbox"/> Active systemic juvenile idiopathic arthritis
<input type="checkbox"/> Active psoriatic arthritis (PsA)	<input type="checkbox"/> Moderate to severe hidradenitis suppurativa
<input type="checkbox"/> Non-infectious intermediate, posterior or panuveitis uveitis	
<input type="checkbox"/> Other _____	
2. What is the ICD-10 code? \_\_\_\_\_
3. Has the patient received any of the following medications in a paid claim through a pharmacy or medical benefit in the previous 120 days? ***If Yes, please specify the most recent medication.***

<input type="checkbox"/> Actemra	<input type="checkbox"/> Cimzia	<input type="checkbox"/> Cosentyx	<input type="checkbox"/> Enbrel	<input type="checkbox"/> Entyvio	<input type="checkbox"/> Humira	<input type="checkbox"/> Inflectra	<input type="checkbox"/> Kineret	<input type="checkbox"/> Orencia
<input type="checkbox"/> Remicade	<input type="checkbox"/> Rituxan	<input type="checkbox"/> Simponi	<input type="checkbox"/> Simponi Aria	<input type="checkbox"/> Stelara	<input type="checkbox"/> Taltz	<input type="checkbox"/> Tysabri	<input type="checkbox"/> Xeljanz	
<input type="checkbox"/> Xeljanz XR	<input type="checkbox"/> No	<i>If No, skip to #7</i>						
4. *If patient is continuing therapy*, how long has the patient been receiving the requested medication?  
 \_\_\_\_\_ weeks / months (**circle one**) ***If the patient has NOT received HUMIRA in a paid claim through a pharmacy or medical benefit in the previous 120 days, skip to #7.***
5. **For ulcerative colitis:** Has the patient achieved clinical remission by day 56 (week 8) of treatment and maintained positive clinical response to treatment as evidenced by low disease activity or improvement in signs and symptoms?  Yes  No
6. **For all other indications:** Has the patient achieved or maintained positive clinical response to treatment as evidenced by low disease activity or improvement in signs and symptoms?  Yes  No
7. Has the patient undergone pretreatment screening for latent tuberculosis (TB) infection with either a TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB)?  Yes  No

***Complete the following section based on the patient's diagnosis, if applicable.***

**Section A: Rheumatoid Arthritis or Polyarticular Juvenile Idiopathic Arthritis**

8. Has the patient experienced an inadequate response after at least 3 months of treatment with methotrexate?  
 Yes  No *If No, skip to #10*

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9. *If diagnosis is RA, what was the MAXIMUM titrated methotrexate dose? \_\_\_\_\_ mg per week  
If greater than or equal to 20 mg per week, no further questions. If diagnosis is pJIA, no further questions.*

10. Has the patient experienced intolerance to methotrexate? *If Yes, no further questions*  Yes  No

11. Does the patient have a contraindication to methotrexate?  Yes  No

*If Yes, indicate contraindication: \_\_\_\_\_*

Section B: Ankylosing Spondylitis or Axial Spondyloarthritis

12. Has the patient experienced an inadequate response with at least TWO nonsteroidal anti-inflammatory drugs (NSAIDs) over a 4-week period in total at the maximum recommended or tolerated anti-inflammatory dose?  
*If Yes no further questions*  Yes  No

13. Does the patient have intolerance or contraindication to at least two NSAIDs?  Yes  No

*If Yes, indicate intolerance or contraindication: \_\_\_\_\_*

Section C: Crohn's Disease

14. Has the patient tried and had an inadequate response to at least one conventional therapy option (e.g., azathioprine [Azasan, Imuran], budesonide [Entocort EC], ciprofloxacin [Cipro], mesalamine [Asacol, Delzicol, Pentasa, Lialda], mercaptopurine [Purinethol], methylprednisolone [Solu-Medrol], methotrexate, metronidazole [Flagyl], prednisone, sulfasalazine [Azulfidine, Sulfazine], rifaximin [Xifaxan])?  Yes  No

*If Yes, indicate the previous treatment regimen and no further questions. \_\_\_\_\_*

15. Does the patient have a contraindication or intolerance to any of the medications listed above?  Yes  No

*If Yes, indicate intolerance or contraindication: \_\_\_\_\_*

Section D: Ulcerative Colitis

17. Does the patient have pouchitis?  Yes  No

16. Has the patient tried and had an inadequate response to at least one conventional therapy option (e.g., azathioprine [Azasan, Imuran], corticosteroid [e.g., budesonide, hydrocortisone [Entocort, Uceris], methylprednisolone, prednisone, cyclosporine [Sandimmune], mesalamine [Asacol, Lialda, Pentasa, Canasa, Rowasa], mercaptopurine [Purinethol], sulfasalazine, tacrolimus [Prograf], metronidazole/ciprofloxacin [for pouchitis only])?  Yes  No

*If Yes, indicate the previous treatment regimen and no further questions: \_\_\_\_\_*

18. Does the patient have a contraindication or intolerance to any of the medications listed above?  Yes  No

*If Yes, indicate intolerance or contraindication: \_\_\_\_\_*

Section E: Plaque Psoriasis

19. What is the percentage of body surface area (BSA) affected? \_\_\_\_\_ %

20. *If less than 5% of BSA, are crucial body areas (e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas) affected?*  Yes  No

21. Has the patient experienced an inadequate response to phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine or acitretin? *If Yes, no further questions*  Yes  No

22. Has the patient had an intolerance or adverse event to a trial of phototherapy (e.g., UVB, PUVA) or pharmacologic treatment with methotrexate, cyclosporine or acitretin? *If Yes, no further questions*  Yes  No

23. Does the patient have a clinical reason to avoid pharmacologic treatment with methotrexate, cyclosporine or acitretin?  Yes  No

*If Yes, indicate clinical reason to avoid and no further questions: \_\_\_\_\_*

24. Does the patient have severe psoriasis that warrants a biologic DMARD as first-line therapy?  Yes  No

***I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.***

X \_\_\_\_\_  
**Prescriber or Authorized Signature**

\_\_\_\_\_  
**Date (mm/dd/yy)**