US Family Health Plan Humira (Adalimumab) Prior Authorization Request Form

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program (USFHP).

MAIL ORDER	**If the prescription is to be filled through the USFHP Mail Order Pharmacy, check here** □	RETAIL	**If the prescription is to be filled at a retail pharmacy, check here** □
	• The completed form and the prescription may be **faxed** to **1-617-562-5296** OR • The patient may attach the completed form to the prescription and **mail** it to: **Attn: Pharmacy, 77 Warren Street, Brighton, MA 02135**		• The provider may **call**: **1-877-880-7007** OR • The completed form may be **faxed** to **1-617-562-5296**

Prior authorization criteria and a copy of this form are available at: http://www.usfamilyhealth.org/f-downloadable_forms.html

Drug for which Prior Authorization is requested: Humira (adalimumab)

Step 1 **Please complete patient and physician information** (Please Print)

Patient Name: ______________________ Physician Name: ______________________

Address: ______________________ Address: ______________________

______________________ ______________________

Sponsor ID: ______________________ Phone #: ______________________

Date of Birth: Secure Fax:

Step 2 Please complete the clinical assessment:

1. Is this a continuation of therapy with Humira?	□ Yes Please sign and date. See quantity limits below.	□ No Proceed to Question 2
2. Will the patient be receiving Kineret (anakinra), Enbrel (etanercept), or Remicade (infliximab) in combination with Humira?	□ Yes Coverage not approved	□ No Proceed to Question 3
3. Is Humira being prescribed for the treatment of moderately to severely active rheumatoid arthritis, active psoriatic arthritis, or ankylosing spondylitis?	□ Yes Please sign and date. See quantity limits below.	□ No Proceed to Question 4
4. Is Humira being prescribed for the treatment of moderately to severely active Crohn's disease following an inadequate response to conventional therapy?	□ Yes Please sign and date. See quantity limits below.	□ No Proceed to Question 5
5. Is Humira being prescribed for the treatment of chronic moderate to severe plaque psoriasis in which systemic therapy or phototherapy is indicated?	□ Yes Please sign and date. See quantity limits below.	□ No Proceed to Question 6
6. Is Humira being prescribed for the treatment of moderately to severely active juvenile idiopathic arthritis in patients 4 years of age and older?	□ Yes Please sign and date. See quantity limits below.	□ No Coverage not approved

Quantity limits: limited to 4 weeks at retail; 8 weeks at mail order.
Crohn's Disease starter pack limited to 1 pack (6 pens), no refills.

Step 3 **I certify the above is correct and accurate to the best of my knowledge.**

Please sign and date

______________________________ ______________

Prescriber Signature Date