CarePlus HEALTH PLANS

PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Humira (adalimumab) 64

Phone: 1-866-315-7587 Fax to: 1-800-310-9071

CarePlus manages the pharmacy drug benefit for your patient. Certain requests for prior authorization require additional information from the prescriber. Please provide the following information and fax this form to the number listed above. Information left blank or illegible may delay the review process.

Patient name:	**Prescriber name:**	
Member/subscriber number:	Fax:	Phone:
Patient date of birth:	Office contact:	
Group number:	NPI:	Tax ID:
Address:	Address:	
City, state ZIP:	City, state ZIP:	
	Specialty/facility name (if applicable):	

Drug name:	☐ Expedited/exigent/urgent
Directions/SIG:	By checking this box, I certify an expedited/exigent/urgent review is required. The member has a health condition that may seriously jeopardize his/her life or ability to regain maximum function. **(Please include explanation of exigency in the space below.)**
Quantity:	

Is this a proactive request for a new plan year? Yes____ No____ If yes, please provide plan year:_____

(Please note: All reviews will be processed with generic equivalents for brand drugs whenever possible.)

Please attach pertinent medical history or information for this patient that may support approval and sign this form.

Q1. Please provide diagnosis: (Mark all that apply) *

- ☐ Active ankylosing spondylitis
- ☐ Moderate to severely active Crohn's disease
- ☐ Moderate to severely active ulcerative colitis
- ☐ Active psoriatic arthritis
- ☐ Moderately to severely active rheumatoid arthritis
- ☐ Moderately to severely active polyarticular juvenile idiopathic arthritis
- ☐ Moderate to severe chronic plaque psoriasis
- ☐ Moderate to severe Hidradenitis Suppurativa
- ☐ Uveitis non-infectious, intermediate, posterior, or pan-uveitis
- ☐ Other

Q2. If other, please specify:

Q3. Please provide ICD Diagnostic Codes:

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Patient Name:	**Prescriber Name:**

Q4. Is the request for a reauthorization?

☐ Yes ☐ No

Q5. Has the patient had prior therapy, contraindication or intolerance to any of the following: (Please mark all that apply)

☐ DMARD (disease modifying anti-rheumatic drugs) (e.g. methotrexate, sulfasalazine, hydroxychloroquine, cyclosporine, leflunomide)

☐ NSAIDs (non-steroidal anti-inflammatory drug) (e.g. ibuprofen, meloxicam, naproxen)

☐ Conventional oral systemic treatments (e.g. acitretin, methotrexate, cyclosporine)

☐ 5-aminosalicylic acids (5-ASAs) (e.g. mesalamine, balsalazide)

☐ Corticosteroids (e.g. prednisone, methylprednisolone)

☐ Immunomodulators (e.g. azathioprine or 6-mercaptopurine)

☐ Intravitreal steroid (e.g. triamcinolone, dexamethasone)

☐ Systemic corticosteroid (e.g. prednisone, methylprednisolone)

☐ Anti-metabolite (e.g. methotrexate, azathioprine, mycophenolate)

☐ Calcineurin inhibitor (e.g. cyclosporine, tacrolimus)

☐ None of the above

Q6. Please provide previous therapies used with start/end dates and reason for discontinuing drug(s) that would be pertinent to the review of the drug requested:

Prescriber signature

Date