

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
7. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

Drug Information

8. Drug Name: _____ 9. Dose: _____ 10. Directions: _____
11. Length of Therapy: ___ up to 30 days ___ 60 days ___ 90 days ___ 120 days ___ 180 days ___ 365 days ___ Other: _____

Clinical Information

Request for Crohn's Disease (Adult):

1. Does the beneficiary have a diagnosis of moderate to severe Crohn's Disease? Yes ___ No ___
2. Is the beneficiary on another injectable biologic immunomodulator? Yes ___ No ___
3. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection? Yes ___ No ___
4. Has the beneficiary been tested with Hep B SAG and Core Ab? Yes ___ No ___
5. Has the beneficiary tried and failed Humira, or a clinical reason the beneficiary cannot try Humira? Yes ___ No ___

Request for Ulcerative Colitis (Adult):

1. Does the beneficiary have a diagnosis of Ulcerative Colitis? Yes ___ No ___
2. Is the beneficiary on another injectable biologic immunomodulator? Yes ___ No ___
3. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection? Yes ___ No ___
4. Has the beneficiary been tested with Hep B SAG and Core Ab? Yes ___ No ___
5. Has the beneficiary had a trial and failure of Humira, or a clinical reason beneficiary cannot try Humira? Yes ___ No ___

Request for FDA Approved Diagnosis Not Listed Above:

1. Diagnosis: _____
2. Is the beneficiary on another injectable biologic immunomodulator? Yes ___ No ___
3. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection? Yes ___ No ___
4. Has the beneficiary been tested with Hep B SAG and Core Ab? Yes ___ No ___

Signature of Prescriber: _____ Date: _____

***Prescriber signature mandatory**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406