AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – Humira

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 Ankylosing Spondylitis:

1. Does the beneficiary have a diagnosis of Ankylosing Spondylitis? 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 experienced inadequate symptom relief from treatment with at least two NSAIDS? Yes___ No___
6. Is the beneficiary unable to receive treatment with NSAIDS due to contraindications? Yes___ No___
7. Does the beneficiary have clinical evidence of severe or rapidly progressing disease? Yes___ No___

Request for Crohn's Disease:

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___

Request for Polyarticular Juvenile Idiopathic Arthritis (PJIA):

1. Does the beneficiary have a diagnosis of Polyarticular Juvenile Idiopathic Arthritis? 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 one systemic corticosteroid (e.g., prednisone, methylprednisolone) or methotrexate, leflunomide or sulfasalazine with inadequate response or is unable to take these therapies due to contraindications? Yes___ No___
6. Does the beneficiary have PJIA subtype enthesitis related arthritis? Yes___ No___

Request for Plaque Psoriasis (Adult):

1. Does the beneficiary have a documented definitive diagnosis of moderate-to-severe Chronic Plaque Psoriasis? Yes___ No___
2. Is the beneficiary 18 years of age or older? Yes___ No___
3. Is the beneficiary on another injectable biologic immunomodulator? Yes___ No___
4. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection? Yes___ No___
5. Has the beneficiary been tested with Hep B SAG and Core Ab? Yes___ No___
6. Does the beneficiary have a body surface area (BSA) involvement of at least 3%? Yes___ No___
7. Does the beneficiary have involvement of the palms, soles, head and neck, or genitalia, causing disruption in normal daily activities and/or employment? Yes___ No___
8. Has the beneficiary failed to respond to, or has been unable to tolerate phototherapy and **ONE** of the following medications or beneficiary has contraindications to these treatments: Soriatane (acitretin), Methotrexate, and/or Cyclosporine? Yes___ No___

Request for Psoriatic Arthritis:

1. Does the beneficiary have a documented definitive diagnosis of Psoriatic Arthritis? Yes___ No___
2. Is the beneficiary 18 years of age or older? Yes___ No___
3. Is the beneficiary on another injectable biologic immunomodulator? Yes___ No___
4. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection? Yes___ No___
5. Has the beneficiary been tested with Hep B SAG and Core Ab? Yes___ No___

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

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6. Does the beneficiary have a documented inadequate response or inability to take methotrexate? Yes___ No___

Request for Rheumatoid Arthritis:

1. Does the beneficiary have a diagnosis of Rheumatoid Arthritis? 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 experienced a therapeutic failure/inadequate response with methotrexate or at least one disease modifying antirheumatic drug (e.g., leflunomide, hydroxychloroquine, minocycline, sulfasalazine)? Yes___ No___
6. Is the beneficiary unable to receive methotrexate or disease modifying antirheumatic drug due to contraindications or intolerabilities? Yes___ No___
7. Does the beneficiary have clinical evidence of severe or rapidly progressing disease? Yes___ No___

Request for Ulcerative Colitis:

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___

Request for Hidradenitis Suppurativa: (ages 12 and older)

1. Does the beneficiary have a diagnosis of Hidradenitis Suppurativa (moderate to severe)? 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___

Request for Non-infectious Intermediate Posterior Panuveitis: (ages 2 and older)

1. Does the beneficiary have a diagnosis of Non-infectious Intermediate Posterior Panuveitis? 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___

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.

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