Humira (for Maryland only)

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?
   - ❑ Moderately to severely active rheumatoid arthritis (RA)
   - ❑ Moderate to severe chronic plaque psoriasis
   - ❑ Moderately to severely active Crohn's disease (CD)
   - ❑ Moderately to severely active ulcerative colitis (UC)
   - ❑ Active psoriatic arthritis (PsA)
   - ❑ Non-infectious intermediate, posterior or panuveitis uveitis
   - ❑ Active ankylosing spondylitis (AS)
   - ❑ Active axial spondyloarthritis
   - ❑ Active polyarticular juvenile idiopathic arthritis (pJIA)
   - ❑ Active systemic juvenile idiopathic arthritis
   - ❑ Moderate to severe hidradenitis suppurativa
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. Would the prescriber like to request an override of the step therapy requirement? ❑ Yes ❑ No *If No, skip to #6*
4. Has the member received the medication through a pharmacy or medical benefit within the past 180 days? ❑ Yes ❑ No ***ACTION REQUIRED: Please provide documentation to substantiate the member had a prescription paid for within the past 180 days (i.e. PBM medication history, pharmacy receipt, EOB etc.)***
5. Is the medication effective in treating the member's condition? ❑ Yes ❑ No *Continue to #6 and complete this form in its entirety.*
6. 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.***
   ❑ Actemra ❑ Cimzia ❑ Cosentyx ❑ Enbrel ❑ Entyvio ❑ Humira ❑ Inflectra ❑ Kineret ❑ Orencia
   ❑ Remicade ❑ Rituxan ❑ Simponi ❑ Simponi Aria ❑ Stelara ❑ Taltz ❑ Tysabri ❑ Xeljanz
   ❑ Xeljanz XR ❑ No *If No, skip to #10*
7. *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 #10.***
8. **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
9. **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

10. 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

11. Has the patient experienced an inadequate response after at least 3 months of treatment with methotrexate? ❑ Yes ❑ No *If No, skip to #13*

12. *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.

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

14. Does the patient have a contraindication to methotrexate? ❑ Yes ❑ No
If Yes, indicate contraindication: _____

Section B: Ankylosing Spondylitis or Axial Spondyloarthritis

15. 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

16. 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

17. 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. _____

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 D: Ulcerative Colitis

19. Does the patient have pouchitis? ❑ Yes ❑ No

20. 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:
_____

21. 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

22. What is the percentage of body surface area (BSA) affected? _____ %

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

24. 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

25. 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

26. 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: _____

27. 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)**