KANSAS MEDICAID
PRIOR AUTHORIZATION
Adalimumab (Humira®)

27271

Request Date ___ / ___ / ____

BENEFICIARY INFORMATION

Beneficiary Medicaid ID Number

Beneficiary Date of Birth ___ / ___ / ____

Beneficiary Full Name

PRESCRIBER INFORMATION

Prescriber's Full Name

Prescriber Street Address

City

State

Zip Code -

Prescriber Phone: - -

Prescriber Fax: - -

Prescriber Medicaid ID #

Prescriber NPI #

NDC Requested:

Strength _____ Quantity _____ Length of Therapy on Prescription _____

OR - Procedure Code requested: _____ Total # of units requested per 6 months: _____

Prescription instructions(sig):_____

1. Please indicate the diagnosis and severity for which Humira® is being prescribed (no dx codes):

_____

2. Prescribed by Rheumatologist? Yes ___ No ___

3. Prescribed by Dermatologist? Yes ___ No____

4. For Plaque Psoriasis: Is patient a candidate for phototherapy or systemic therapy? Yes____ No___
Documentation that systemic therapies are medically less appropriate_____

_____

5. For Crohn's disease: Documentation of inadequate response to conventional therapies:

_____

6. Prescribed by a Gastroenterologist? Yes _____ No _____

7. TB skin test results: Date: ____/_____/_____ Positive _____ Negative _____

Signature of Prescriber_____ Date ___ / ___ / ____

*Prescriber signature mandatory

FAX TO: **KANSAS Medicaid Prior Authorizations**
Fax: (866) 246-8512
PA HELPDESK: (877) 475 - 7567

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August 2011