



Humira® (Adalimumab) Prior Authorization Request Form

Beneficiary Information

Name: _____
Medicaid ID #: _____ Date of Birth: _____

Billing Provider Information (Pharmacy, Physician, or Facility)

Name: _____ Medicaid ID #: _____
NPI #: _____ Phone #: _____ Fax #: _____
Requested Drug: _____ NDC: _____
Requested Procedure Code (if applicable) _____ Total # of Units Requested (per 6 months) _____

Prescriber Information

Name: _____ Medicaid ID # _____
NPI #: _____ Phone #: _____ Fax #: _____

Requested Information

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

2. What is specialty of the prescriber?
 Rheumatologist Dermatologist Gastroenterologist Other (please specify): _____
3. Lab results:
TB Skin Test Date: _____ TB Skin Test Result: Positive Negative
4. Has the patient taken any biologics in the past 30 days? Yes No
If 'Yes', which agent(s): _____
5. For **Adult Crohn's Disease** or **Ulcerative Colitis** list conventional therapies the patient has tried

OR document contraindications, inadequate response, side effects or allergy to conventional therapies:

6. For **Pediatric Crohn's Disease**, has patient had inadequate response to corticosteroids or immunomodulators?
 Yes No
7. For **Plaque Psoriasis**, has patient taken an oral agent for treatment of plaque psoriasis? Yes No
OR Is patient a candidate for systemic therapy or phototherapy? Yes No

Prescriber's Signature: _____ **Date:** _____

**The completed form should be faxed to the HP Prior Authorization Unit at 1-800-913-2229.
This form will be returned unprocessed if it is not completed in its entirety.**