PRIORITY PARTNERS
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

Prior Authorization

JOHNS HOPKINS HEALTH PLANS

Humira and Biosimilars - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at **1-410-424-4607**.
Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Humira and Biosimilars - Priority Partners MCO.

Drug Name
(specify drug) _____

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Has the plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

NOTE: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.

[If yes, skip to question 66.]

2.	Does the patient have ANY of the following diagnoses: A) sarcoidosis, B) graft-versus-host disease, C) interleukin-2 toxicity, D) Langerhan's cell histiocytosis, E) myositis, F) nephrotic syndrome, G) amyloidosis, H) periodic fever syndrome, I) renal transplant syndrome, J) First-line therapy for pediatric patients with moderate to severe Crohn's disease, OR K) definitive radiographic axial spondyloarthritis with evidence of structural damage on sacroiliac joints?	Y N
	[If yes, no further questions.]	
3.	Does the patient have a diagnosis of rheumatoid arthritis?	Y N
	NOTE: Submission of medical records is required.	
	[If no, skip to question 10.]	
4.	Is the request for Amjevita, Cyltezo, Hulio, Humira, Hyrimoz, Idacio, Yuflyma, or Yusimry?	Y N
	[If no, skip to question 6.]	
5.	Has the patient had a trial and inadequate response or intolerance with Hadlima, adalimumab-adaz, or adalimumab-fkjp?	Y N
	[If no, no further questions.]	
6.	Has the patient tried and had treatment failure to at least TWO formulary disease-modifying antirheumatic drugs (DMARDs) including methotrexate?	Y N
	NOTE: Submission of medical records is required.	
	[If yes, skip to question 9.]	
7.	Does the patient have a contraindication to at least TWO formulary disease-modifying antirheumatic drugs (DMARDs) including methotrexate?	Y N
	NOTE: Submission of medical records is required.	
	[If yes, skip to question 9.]	
8.	Has the patient had rheumatoid arthritis for less than or equal to 6 months with high level of disease activity and features of poor prognosis (such as extra-articular disease, positive rheumatoid factor, or bony erosions)?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
9.	Is the patient 18 years of age or older?	Y N
	[If yes, skip to question 71.]	
	[If no, no further questions.]	
10.	Does the patient have a diagnosis of juvenile idiopathic arthritis?	Y N
	NOTE: Submission of medical records is required.	
	[If no, skip to question 17.]	

11. Is the request for Amjevita, Cyltezo, Hulio, Humira, Hyrimoz, Idacio, Yuflyma, or Yusimry?	Y N	
[If no, skip to question 13.]		
12. Has the patient had a trial and inadequate response or intolerance with Hadlima, adalimumab-adaz, or adalimumab-fkjp?	Y N	
[If no, no further questions.]		
13. Has the patient tried and had insufficient response to an adequate trial of full dose nonsteroidal anti-inflammatory drug (NSAID) therapy?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
14. Has the patient tried and had insufficient response to at least TWO formulary disease-modifying antirheumatic drugs (DMARDs) including methotrexate?	Y N	
NOTE: Submission of medical records is required.		
[If yes, skip to question 16.]		
15. Does the patient have a contraindication to at least TWO disease-modifying antirheumatic drugs (DMARDs) including methotrexate?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
16. Is the patient 2 years of age or older?	Y N	
[If yes, skip to question 71.]		
[If no, no further questions.]		
17. Does the patient have a diagnosis of psoriatic arthritis?	Y N	
NOTE: Submission of medical records is required.		
[If no, skip to question 23.]		
18. Is the request for Amjevita, Cyltezo, Hulio, Humira, Hyrimoz, Idacio, Yuflyma, or Yusimry?	Y N	
[If no, skip to question 20.]		
19. Has the patient had a trial and inadequate response or intolerance with Hadlima, adalimumab-adaz, or adalimumab-fkjp?	Y N	
[If no, no further questions.]		
20. Has the patient tried and had insufficient response to at least TWO disease-modifying antirheumatic drugs (DMARDs) including methotrexate?	Y N	
NOTE: Submission of medical records is required.		
[If yes, skip to question 22.]		
21. Does the patient have a contraindication to at least TWO disease-modifying antirheumatic drugs (DMARDs) including methotrexate?	Y N	

NOTE: Submission of medical records is required.		
[If no, no further questions.]		
22. Is the patient 18 years of age or older?	Y N	
[If yes, skip to question 71.]		
[If no, no further questions.]		
23. Does the patient have a diagnosis of ankylosing spondylitis?	Y N	
NOTE: Submission of medical records is required.		
[If no, skip to question 28.]		
24. Is the request for Amjevita, Cyltezo, Hulio, Humira, Hyrimoz, Idacio, Yuflyma, or Yusimry?	Y N	
[If no, skip to question 26.]		
25. Has the patient had a trial and inadequate response or intolerance with Hadlima, adalimumab-adaz, or adalimumab-fkjp?	Y N	
[If no, no further questions.]		
26. Has the patient tried and had insufficient response to an adequate trial of TWO full doses nonsteroidal anti-inflammatory drug (NSAID) therapies?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
27. Is the patient 18 years of age or older?	Y N	
[If yes, skip to question 71.]		
[If no, no further questions.]		
28. Does the patient have a diagnosis of chronic moderate to severe plaque psoriasis?	Y N	
NOTE: Submission of medical records is required.		
[If no, skip to question 36.]		
29. Is the request for Amjevita, Cyltezo, Hulio, Humira, Hyrimoz, Idacio, Yuflyma, or Yusimry?	Y N	
[If no, skip to question 31.]		
30. Has the patient had a trial and inadequate response or intolerance with Hadlima, adalimumab-adaz, or adalimumab-fkjp?	Y N	
[If no, no further questions.]		
31. Does the patient have EITHER of the following: A) body surface area involvement of greater than 10 percent OR B) body surface area involvement of less than or equal to 10 percent, but involves sensitive areas (palms/soles of feet, genitalia and head/neck)?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		

32. Has the patient tried and had insufficient response or contraindication to at least ONE of the following: A) phototherapy OR B) systemic with methotrexate or cyclosporine?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
33. Does the patient have moderate disease?	Y N	
[If no, skip to question 35.]		
34. Has the patient had a documented trial and insufficient response to topical pharmacologic therapy (corticosteroids, vitamin D analogues, or retinoids), unless their use is contraindicated?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
35. Is the patient 18 years of age or older?	Y N	
[If yes, skip to question 71.]		
[If no, no further questions.]		
36. Does the patient have a diagnosis of moderately to severely active Crohn's disease?	Y N	
NOTE: Submission of medical records is required.		
[If no, skip to question 41.]		
37. Is the request for Amjevita, Cyltezo, Hulio, Humira, Hyrimoz, Idacio, Yuflyma, or Yusimry?	Y N	
[If no, skip to question 39.]		
38. Has the patient had a trial and inadequate response or intolerance with Hadlima, adalimumab-adaz, or adalimumab-fkjp?	Y N	
[If no, no further questions.]		
39. Has the patient tried and had insufficient response to corticosteroids, or immunomodulators such as azathioprine, 6-mercaptopurine, or methotrexate?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
40. Is the patient at least 6 years of age or older?	Y N	
[If yes, skip to question 71.]		
[If no, no further questions.]		
41. Does the patient have a diagnosis of moderate to severe ulcerative colitis?	Y N	
NOTE: Submission of medical records is required.		
[If no, skip to question 50.]		
42. Is the request for Amjevita, Cyltezo, Hulio, Hyrimoz, Idacio, Yuflyma, or Yusimry?	Y N	

[If no, skip to question 44.]		
43. Has the patient had a trial and inadequate response or intolerance with Hadlima, adalimumab-adaz, or adalimumab-fkjp?	Y N	
[If yes, skip to question 48.]		
[If no, no further questions.]		
44. Is the request for Humira?	Y N	
[If no, skip to question 48.]		
45. Is the patient 5 to 17 years of age?	Y N	
[If yes, skip to question 49.]		
46. Is the patient 18 years of age or older?	Y N	
[If no, no further questions.]		
47. Has the patient had a trial and inadequate response or intolerance with Hadlima, adalimumab-adaz, or adalimumab-fkjp?	Y N	
[If yes, skip to question 49.]		
[If no, no further questions.]		
48. Is the patient 18 years of age or older?	Y N	
[If no, no further questions.]		
49. Has the patient tried and had insufficient response to immunosuppressants such as corticosteroids, azathioprine, or 6-mercaptopurine (6-MP)?	Y N	
NOTE: Submission of medical records is required.		
[If yes, skip to question 71.]		
[If no, no further questions.]		
50. Does the patient have a diagnosis of moderate to severe hidradenitis suppurativa (HS)?	Y N	
NOTE: Submission of medical records is required.		
[If no, skip to question 58.]		
51. Is the request for Amjevita, Cyltezo, Hulio, Hyrimoz, Idacio, Yuflyma, or Yusimry?	Y N	
[If no, skip to question 53.]		
52. Has the patient had a trial and inadequate response or intolerance with Hadlima, adalimumab-adaz, or adalimumab-fkjp?	Y N	
[If yes, skip to question 54.]		
[If no, no further questions.]		
53. Is the request for Humira?	Y N	
[If yes, skip to question 55.]		
54. Is the patient 18 years of age or older?	Y N	
[If yes, skip to question 71.]		

[If no, no further questions.]	
55. Is the patient 12 years of age or older?	Y N
[If no, no further questions.]	
56. Is the patient 12 to 17 years of age?	Y N
[If yes, skip to question 71.]	
57. Has the patient had a trial and inadequate response or intolerance with Hadlima, adalimumab-adaz, or adalimumab-fkjp?	Y N
[If yes, skip to question 71.]	
[If no, no further questions.]	
58. Does the patient have a diagnosis of ONE of the following types of non-infectious uveitis: A) intermediate uveitis, B) posterior uveitis, OR C) panuveitis?	Y N
[If no, no further questions.]	
59. Is the request for Amjevita, Cyltezo, Hulio, Hyrimoz, Idacio, Yuflyma, or Yusimry?	Y N
[If no, skip to question 61.]	
60. Has the patient had a trial and inadequate response or intolerance with Hadlima, adalimumab-adaz, or adalimumab-fkjp?	Y N
[If yes, skip to question 62.]	
[If no, no further questions.]	
61. Is the request for Humira?	Y N
[If yes, skip to question 63.]	
62. Is the patient 18 years of age or older?	Y N
[If yes, skip to question 71.]	
[If no, no further questions.]	
63. Is the patient 2 to 17 years of age?	Y N
[If yes, skip to question 71.]	
64. Is the patient 18 years of age or older?	Y N
[If no, no further questions.]	
65. Did the patient have a trial and had an inadequate response or intolerance with Hadlima, adalimumab-adaz, or adalimumab-fkjp?	Y N
[If yes, skip to question 71.]	
[If no, no further questions.]	
66. Does the patient have ANY of the following diagnoses: A) sarcoidosis, B) graft-versus-host disease, C) interleukin-2 toxicity, D) Langerhan's cell histiocytosis, E) myositis, F) nephrotic syndrome, G) amyloidosis, H) periodic fever syndrome, I) renal transplant syndrome, J) First-line therapy for pediatric patients with moderate to severe	Y N

Crohn's disease, OR K) definitive radiographic axial spondyloarthritis with evidence of structural damage on sacroiliac joints?		
[If yes, no further questions.]		
67. Does the patient have ONE of the following diagnoses: A) rheumatoid arthritis, B) juvenile idiopathic arthritis, C) psoriatic arthritis, D) ankylosing spondylitis, E) plaque psoriasis, F) hidradenitis suppurativa, OR G) uveitis?	Y N	
NOTE: Submission of medical records is required.		
[If no, skip to question 69.]		
68. Is the patient experiencing clinical improvement from treatment as supported by ONE of the following outcomes: A) reduction in the signs and symptoms, B) prolonged beneficial clinical response, C) inhibition of structural damage progression, OR D) improved physical functioning?	Y N	
NOTE: Submission of medical records is required.		
[If yes, skip to question 71.]		
[If no, no further questions.]		
69. Does the patient have ONE of the following diagnoses: A) Crohn's disease OR B) ulcerative colitis?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
70. Is the patient experiencing clinical improvement from treatment as supported by ONE of the following outcomes: A) reduction in gastrointestinal signs and symptoms, B) prolonged clinical remission and mucosal healing, OR C) reduced number of draining enterocutaneous or rectovaginal fistulas for at least a 3-month period (only applies to fistulizing Crohn's disease)?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
71. Is the requested medication being prescribed for FDA-approved dosages and dosing intervals?	Y N	
NOTE: Submission of medical records is required.		
[If no, no further questions.]		
72. Will the requested medication be used concurrently with another biologic disease-modifying anti-rheumatic drug (DMARD)?	Y N	

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date