TRICARE Prior Authorization Request Form for

Abrilada, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, Yuflyma, Yusimry

JOHNS HOPKINS HEALTH PLANS

7231 Parkway Drive, Suite 100, Hanover, MD 21076

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Prior authorization does not expire.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID # _____ Phone #: _____

Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. The originator Humira formulation is the preferred product over the biosimilar adalimumab formulations.	☐ Acknowledged Proceed to question **2**	
2. Please provide a patient-specific justification as to why the originator Humira product cannot be used in this patient	_____ Proceed to question **3**	
3. Is the patient 18 years of age or older?	☐ Yes proceed to question **11**	☐ No proceed to question **4**
4. What is the indication or diagnosis in this pediatric patient? Note: Non-FDA-approved uses are NOT approved, with the exception that if an indication is approved for Humira, it is approved for a biosimilar.	☐ moderate to severe active **polyarticular juvenile idiopathic arthritis (pJIA)** – proceed to question **5** ☐ moderately to severely active **Crohn's disease** – proceed to question **7** ☐ **Severe chronic plaque psoriasis** in patients who are candidates for systemic or phototherapy, and when other systemic therapies are medically less appropriate (4-17 years) – go to question **10** ☐ moderately to severely active **ulcerative colitis** – go to question **6** ☐ treatment of **uveitis** (non-infectious intermediate, posterior and panuveitis patients) – go to question **5** ☐ **Hidradenitis suppurativa** – go to question **8** ☐ Other indication or diagnosis – **STOP**: Coverage not approved.	

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5. Is the patient 2 years of age or older?	☐ Yes proceed to question **15**	☐ No **STOP** **Coverage not approved**
6. Is the patient 5 years of age or older?	☐ Yes proceed to question **10**	☐ No **STOP** **Coverage not approved**
7. Is the patient 6 years of age or older?	☐ Yes proceed to question **9**	☐ No **STOP** **Coverage not approved**
8. Is the patient 12 years of age or older?	☐ Yes proceed to question **15**	☐ No **STOP** **Coverage not approved**
9. Does the patient have fistulizing CD?	☐ Yes proceed to question **15**	☐ No proceed to question **10**
10. Has the patient had an inadequate response to non-biologic systemic therapy? (For example: methotrexate, aminosalicylates [such as, sulfasalazine, mesalamine], corticosteroids, immunosuppressants [such as, azathioprine], etc.)?	☐ Yes proceed to question **15**	☐ No **STOP** **Coverage not approved**

11. What is the indication or diagnosis in this adult patient? Note: Non-FDA-approved uses are NOT approved, with the exception that if an indication is approved for Humira, it is approved for a biosimilar.	☐ moderately to severely active **rheumatoid arthritis** – go to question **14** ☐ active **psoriatic arthritis** – go to question **15** ☐ **Ankylosing spondylitis** – go to question **12** ☐ Active non-radiographic axial spondyloarthritis (nr-ax SpA) with objective signs of inflammation – go to question **14** ☐ moderate to severe **chronic plaque psoriasis** in a patient who may benefit from taking injection or pills (systemic therapy) or phototherapy – go to question **14** ☐ moderately to severely active **Crohn's disease** – go to question **13** ☐ moderately to severely active **ulcerative colitis** – go to question **14** ☐ moderately to severely active **pyoderma gangrenosum (PG)** that is refractory to high-potency corticosteroids– go to question **15** ☐ treatment of **uveitis** (non-infectious intermediate, posterior and panuveitis patients) – go to question **15** ☐ **Hidradenitis suppurativa** – go to question **15** ☐ Other indication or diagnosis – **STOP: Coverage not approved.**

12. Has the patient had an inadequate response to at least two NSAIDS over a period of at least two months?	☐ Yes proceed to question **15**	☐ No **STOP** **Coverage not approved**
13. Does the patient have fistulizing CD?	☐ Yes proceed to question **15**	☐ No proceed to question **14**
14. Has the patient had an inadequate response to non-biologic systemic therapy? (For example: methotrexate, aminosalicylates [such as, sulfasalazine, mesalamine], corticosteroids, immunosuppressants [such as, azathioprine], etc.)?	☐ Yes proceed to question **15**	☐ No **STOP** **Coverage not approved**

15. Cases of worsening congestive heart failure (CHF) and new onset CHF have been reported with TNF blockers, including HUMIRA. Is the prescriber aware of this?	☐ Yes proceed to question **16**	☐ No **STOP** **Coverage not approved**
16. Has the patient had evidence of a negative TB test result in the past 12 months (or TB is adequately managed)?	☐ Yes proceed to question **17**	☐ No **STOP** **Coverage not approved**
17. Will the patient be receiving other targeted immunomodulatory biologics with Humira, including but not limited to the following: certolizumab (Cimzia), etanercept (Enbrel), golimumab (Simponi), infliximab (Remicade), apremilast (Otezla), ustekinumab (Stelara), abatacept (Orencia), anakinra (Kineret), tocilizumab (Actemra), tofacitinib (Xeljanz/Xeljanz XR), rituximab (Rituxan), secukinumab (Cosentyx), ixekizumab (Taltz), brodalumab (Siliq), sarilumab (Kevzara), guselkumab (Tremfya), baricitinib (Olumiant), tildrakizumab (Ilumya), risankizumab (Skyrizi), or upadacitinib (Rinvoq ER)?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

Prescriber Signature _____ Date _____

[14 Feb 2024]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: