TRICARE Prior Authorization Request Form for
adalimumab **(Humira)**

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.

When prescribed by a rheumatologist, prior authorization is not required. Prior authorization is required when prescribed in other situations.

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. Is the medication being prescribed by a rheumatologist?	☐ Yes **Sign and date below**	☐ No proceed to question **2**
2. Is the patient 18 years of age or older?	☐ Yes proceed to question **9**	☐ No proceed to question **3**
3. What is the indication or diagnosis in this pediatric patient?	☐ moderate to severe active **polyarticular juvenile idiopathic arthritis (pJIA)** - proceed to question **4** ☐ treatment of **uveitis** (non-infectious intermediate, posterior and panuveitis patients) - proceed to question **4** ☐ moderately to severely active **Crohn's disease** – proceed to question **6** ☐ **hidradenitis suppurativa** – go 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 **8** ☐ moderately to severely active **ulcerative colitis** – go to question **5** ☐ Other indication or diagnosis – **STOP**: Coverage not approved. **Please document diagnosis:** _____	
4. Is the patient 2 years of age or older?	☐ Yes proceed to question **13**	☐ No **STOP** **Coverage not approved**
5. Is the patient 5 years of age or older?	☐ Yes proceed to question **8**	☐ No **STOP** **Coverage not approved**

6. Is the patient 6 years of age or older?	☐ Yes proceed to question **13**	☐ No **STOP** **Coverage not approved**
7. Is the patient 12 years of age or older?	☐ Yes proceed to question **13**	☐ No **STOP** **Coverage not approved**
8. 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 **13**	☐ No **STOP** **Coverage not approved**

9. What is the indication or diagnosis in this adult patient?

- ☐ moderately to severely active **rheumatoid arthritis** – go to question **12**
- ☐ active **psoriatic arthritis** – go to question **13**
- ☐ **Ankylosing spondylitis** – go to question **10**
- ☐ Active non-radiographic axial spondyloarthritis (nr-ax SpA) with objective signs of inflammation – go to question **12**
- ☐ moderate to severe **chronic plaque psoriasis** in a patient who may benefit from taking injection or pills (systemic therapy) or phototherapy – go to question **12**
- ☐ moderately to severely active **Crohn's disease** – go to question **11**
- ☐ moderately to severely active **ulcerative colitis** – go to question **12**
- ☐ **hidradenitis suppurativa** – go to question **13**
- ☐ treatment of **uveitis** (non-infectious intermediate, posterior and panuveitis patients)– go to question **12**
- ☐ moderately to severely active **pyoderma gangrenosum (PG)** that is refractory to high-potency corticosteroids– go to question **13**
- ☐ Other indication or diagnosis – **STOP: Coverage not approved.**

Please document diagnosis: _____

10. Has the patient had an inadequate response to at least two NSAIDS over a period of at least two months?	☐ Yes proceed to question **13**	☐ No **STOP** **Coverage not approved**
11. Does the patient have fistulizing CD?	☐ Yes proceed to question **13**	☐ No proceed to question **12**
12. 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 **13**	☐ No **STOP** **Coverage not approved**
13. 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 **14**	☐ No **STOP** **Coverage not approved**
14. 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 **15**	☐ No **STOP** **Coverage not approved**

15. 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

[03 Jan 2024]

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