TRICARE Prior Authorization Request Form for
adalimumab **(preferred brand 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.

Note that the PA applies to the branded Humira formulation by Abbvie. The Cordavis brand is completely excluded from the TRICARE benefit.

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 **5**	☐ No proceed to question **3**
3. Is the patient 2 years of age or older?	☐ Yes proceed to question **4**	☐ No **STOP** **Coverage not approved**

4. What is the indication or diagnosis in this pediatric patient?

- ☐ Moderate to severe active **polyarticular idiopathic arthritis (JIA), including subtypes** - proceed to question **8**
- ☐ Treatment of **uveitis** (non-infectious intermediate, posterior and panuveitis patients) – proceed to question **8**
- ☐ Moderately to severely active **Crohn's disease** – proceed to question **9**
- ☐ Moderate to severe **hidradenitis suppurativa** – proceed to question **8**
- ☐ **Moderate to severe plaque psoriasis** in patients who are candidates for systemic or phototherapy– proceed to question **9**
- ☐ Moderately to severely active **ulcerative colitis** – proceed to question **8**
- ☐ Other indication or diagnosis – **STOP**: Coverage not approved.

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5.	**What is the indication or diagnosis in this adult patient?**	☐ Moderately to severely active **rheumatoid arthritis** – proceed to question **8** ☐ Active **psoriatic arthritis** – proceed to question **9** ☐ Active **ankylosing spondylitis** – proceed to question **6** ☐ Active **non-radiographic axial spondyloarthritis (nr-ax SpA)** with objective signs of inflammation – proceed to question **6** ☐ Moderate to severe **chronic plaque psoriasis** in patients who are candidates for systemic therapy or phototherapy – proceed to question **8** ☐ Moderately to severely active **Crohn's disease** – proceed to question **7** ☐ Moderately to severely active **ulcerative colitis** – proceed to question **8** ☐ Moderate to severe **hidradenitis suppurativa** – proceed to question **8** ☐ Treatment of **uveitis** (non-infectious intermediate, posterior and panuveitis patients)– proceed to question **8** ☐ Moderately to severely active **pyoderma gangrenosum (PG)** that is refractory to high-potency corticosteroids– proceed to question **8** ☐ Other indication or diagnosis – **STOP: Coverage not approved.**	
6.	**Has the patient had an inadequate response to at least two NSAIDS over a period of at least two months?**	☐ Yes proceed to question **9**	☐ No **STOP** **Coverage not approved**
7.	**Does the patient have fistulizing CD?**	☐ Yes proceed to question **9**	☐ No proceed to question **8**
8.	**Has the patient had an inadequate response to non-biologic systemic therapy, antibiotics or anti-androgens? (For example: methotrexate, aminosalicylates [such as, sulfasalazine, mesalamine], corticosteroids, immunosuppressants [such as, azathioprine], etc.)?**	☐ Yes proceed to question **9**	☐ No **STOP** **Coverage not approved**
9.	**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 **10**	☐ No **STOP** **Coverage not approved**
10.	**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 **11**	☐ No **STOP** **Coverage not approved**
11.	**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, apremilast (Otezla), ustekinumab (Stelara), abatacept (Orencia), anakinra (Kineret), tocilizumab, 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**

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

Prescriber Signature Date

[02 October 2024]

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