TRICARE Prior Authorization Request Form for
adalimumab (Humira)

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

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

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

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

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

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 patient 18 years of age or older?	☐ Yes proceed to question **9**	☐ No proceed to question **2**
2. What is the indication or diagnosis in this pediatric patient?	☐ moderate to severe active **polyarticular juvenile idiopathic arthritis (pJIA)** - proceed to question **3** ☐ treatment of **uveitis** (non-infectious intermediate, posterior and panuveitis patients) - proceed to question **3** ☐ moderately to severely active **Crohn's disease** – proceed to question **5** ☐ **hidradenitis suppurativa** – go to question **6** ☐ **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 **4** ☐ Other indication or diagnosis – **STOP**: Coverage not approved. **Please document diagnosis:** _____	
3. Is the patient 2 years of age or older?	☐ Yes proceed to question **13**	☐ No **STOP** **Coverage not approved**
4. Is the patient 5 years of age or older?	☐ Yes proceed to question **8**	☐ No **STOP** **Coverage not approved**
5. Is the patient 6 years of age or older?	☐ Yes proceed to question **7**	☐ No **STOP** **Coverage not approved**
6. Is the patient 12 years of age or older?	☐ Yes proceed to question **13**	☐ No **STOP** **Coverage not approved**

7.	**Does the patient have fistulizing CD?**	☐ Yes proceed to question **13**	☐ No proceed to question **8**
8.	**Has the patient had an inadequate response to non-biologic systemic therapy? (For example: methotrexate, aminosalicylates [e.g. sulfasalazine, mesalamine], corticosteroids, immunosuppressants [e.g. 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 **12** ☐ **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

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