

**Neighborhood Health Plan of Rhode Island
Prior Authorization Form
Humira® (Adalimumab)**

If approval criteria are met, Neighborhood Health Plan of Rhode Island will authorize coverage of Humira® (adalimumab). Failure to fill out this form will result in a rejection of this medication at the pharmacy. Thank you for your assistance.

Please complete the following information:

Member Name: (required)	Member ID Number: (required) <table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>										
Member Date of Birth: (required) / /	Member Sex: M F (Circle One)										
Prescriber Name: (required)	Contact Person at Office:										
Office Phone number: (required) () -	Office Fax Number: (required) () -										

*****Directions of use :**

INDICATIONS FOR USE	YES	NO
1) FOR REDUCTION IN SIGNS AND SYMPTOMS AND INHIBITION OF THE PROGRESSION OF STRUCTURAL DAMAGE IN PATIENTS WITH MODERATELY TO SEVERELY ACTIVE RHEUMATOID ARTHRITIS (RA).	<input type="checkbox"/>	<input type="checkbox"/>
2) FOR THE REDUCTION IN SIGNS AND SYMPTOMS OF ARTHRITIS IN PATIENTS WITH PSORIATIC ARTHRITIS.	<input type="checkbox"/>	<input type="checkbox"/>
3) FOR THE REDUCTION OF SIGNS AND SYMPTOMS IN PATIENTS WITH ACTIVE ANKYLOSING SPONDYLITIS	<input type="checkbox"/>	<input type="checkbox"/>
4) PATIENT HAS HAD AN UNSATISFACTORY RESPONSE TO A PREVIOUS TRIAL OF A DISEASE MODIFYING ANTIRHEUMATIC DRUG (DMARD) OR PREVIOUS TNF THERAPY (I.E. HYDROXYCHLOROQUINE (PLAQUENIL®), AZATHIOPRINE (IMURAN®), SULFASALAZINE (AZULFIDINE®), CYCLOPHOSPHAMIDE (CYTOXAN®), CYCLOSPORINE (NEORAL®), METHOTREXATE), ANAKINRA (KINERET®), ETC PLEASE LIST PRIOR THERAPIES: a) _____ b) _____ c) _____	<input type="checkbox"/>	<input type="checkbox"/>
5) IF THIS IS FOR RENEWAL, HAS PATIENT SHOWN SYMPTOMATIC IMPROVEMENT? PLEASE DESCRIBE: _____ _____ _____	<input type="checkbox"/>	<input type="checkbox"/>
6) IS PATIENT HYPERSENSITIVE TO HUMIRA OR ANY OF ITS COMPONENTS?	<input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> ▪ Patients should be evaluated for latent tuberculosis with a tuberculin skin test prior to adalimumab therapy. Treatment of latent TB should be initiated before infliximab is used. ▪ Rare reactivation of hepatitis B has occurred in chronic virus carriers. ▪ Use caution in patients with pre-existing or recent-onset demyelinating CNS disorders. 		

BENEFIT TERMS UPON APPROVAL:

INITIAL APPROVAL WILL BE FOR 4 MONTHS AT WHICH TIME PATIENT SHOULD BE EVALUATED FOR RESPONSE TO THERAPY. IF PATIENT IS RESPONDING TO THERAPY, AN ADDITIONAL 9 MONTHS WILL BE APPROVED.

All information provided on this form is accurate as of this date.

Provider Signature: _____ **NPI:** _____ **Date:** _____

Directions for Humira _____

Completed forms should be faxed to: Customer Service Department (866) 423-0945