

## 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:

<b>Member Name:</b> (required)	<b>Member ID Number:</b> (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>										
<b>Member Date of Birth:</b> (required) / /	<b>Member Sex:</b> M    F    (Circle One)										
<b>Prescriber Name:</b> (required)	<b>Contact Person at Office:</b>										
<b>Office Phone number:</b> (required) (    ) -	<b>Office Fax Number:</b> (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) FOR TREATMENT OF PATIENTS >18 WITH CHRONIC MODERATE TO SEVERE PLAQUE PSORIASIS	<input type="checkbox"/>	<input type="checkbox"/>
5) FOR REDUCTION OF SIGNS AND SYMPTOMS OF MODERATE TO SEVERE CROHN'S DISEASE	<input type="checkbox"/>	<input type="checkbox"/>
6) FOR REDUCTION OF SIGNS AND SYMPTOMS OF MODERATE TO SEVERE POLYARTICULAR-COURSE JUVENILE RA	<input type="checkbox"/>	<input type="checkbox"/>
7) 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"/>
8) IF THIS IS FOR RENEWAL, HAS PATIENT SHOWN SYMPTOMATIC IMPROVEMENT? PLEASE DESCRIBE: _____ _____	<input type="checkbox"/>	<input type="checkbox"/>
<ul style="list-style-type: none"> <li>▪ <b>Patients should be evaluated for latent tuberculosis with a tuberculin skin test prior to adalimumab therapy. Treatment of latent TB should be initiated before adalimumab is used.</b></li> <li>▪ <b>Rare reactivation of hepatitis B has occurred in chronic virus carriers.</b></li> <li>▪ <b>Use caution in patients with pre-existing or recent-onset demyelinating CNS disorders.</b></li> </ul>		

**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:** \_\_\_\_\_

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