



Send completed form to:
 Peach State Health Plan Pharmacy Department
 Fax: 1-866-374-1579

Humira

Prior Authorization Request

This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form toll-free to Peach State Health Plan at 1-866-374-1579.** If you have questions regarding the prior authorization, eligibility, drug copy or medication delivery; please contact Peach State Health Plan at 1-800-514-0083 option # 2.

Patient Name: _____ **Date:** _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Physician Office Address: _____

1. Which drug(s) are being prescribed? Humira, Dose: _____ Frequency: _____ Other _____
2. What is the diagnosis?

<input type="checkbox"/> Psoriatic Arthritis	<input type="checkbox"/> Polyarticular Juvenile Idiopathic Arthritis
<input type="checkbox"/> Ankylosing Spondylitis	<input type="checkbox"/> Plaque Psoriasis
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Other _____
<input type="checkbox"/> Crohn's Disease	
3. What is the patient's age? _____ years
4. What is the medical specialty of the prescribing physician? Rheumatologist Dermatologist
 Gastroenterologist Colorectal Specialist Other _____
5. Does the patient have negative tuberculosis (TB) test? **If yes, skip to # 8* Yes No
6. Has active TB been ruled out via negative chest x-ray? Yes No
7. Was chest x-ray taken within last 12 months? Yes No
8. Does the patient have signs or symptoms of active infection, either chronic or localized?
 Yes No
9. Does the patient have a history of hepatitis B infection? Yes No
10. Has the patient been treated for hepatitis B infection? Yes No
11. Does the patient have a history of any of the following diseases? Yes No

<input type="checkbox"/> Congestive cardiac failure (New York Heart Association grade III or IV)
<input type="checkbox"/> Multiple sclerosis or other demyelinating disease
<input type="checkbox"/> Malignant disease
12. Will Humira be used in combination with any other biologic medication(s)? Yes No
13. Is the patient currently receiving Humira therapy? Yes No **If no, skip to # 17*
14. Is the patient compliant with Humira therapy? Yes No

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Patient Name: _____ Patients Date of Birth: _____
Patients ID : _____

15. Did the patient demonstrate a therapeutic response? Yes No
16. Did the patient develop malignancy? Yes No
17. Has the patient had a trial of **biologic** therapy other than Humira for 3 consecutive months?
 Yes No **If no, skip to # 20*
 Cimzia Enbrel Kineret Orencia Remicade Rituxan Simponi
18. Has the patient had an inadequate response to previous biologic therapy? Yes No
19. Was the patient adherent to prescribed biologic therapy? Yes, **submit documentation** No
20. Was the patient intolerant to previous biologic therapy? Yes, **submit documentation** No

Complete Section below designated for the patient's diagnosis.

Section A: Rheumatoid Arthritis

21. Prior to therapy, did the patient have 6 or more inflamed joints? Yes No
22. Prior to therapy, did the patient have at least one of the following characteristics? Yes No
 Elevation of erythrocyte sedimentation rate and/or serum c-reactive protein concentration
 Positive rheumatoid factor and/or anti-cyclic citrullinated peptide
 Radiography showing evidence of rheumatoid arthritis, including osteopenia and/or joint space narrowing and/or bony erosions and/or loss of cartilage
23. Has the patient had a trial of either methotrexate or leflunomide for at least 3 consecutive months?
 Yes No **If no, skip to # 25*
24. Has the patient had an inadequate response to either methotrexate or leflunomide?
**If yes, skip to # 29* Yes No
25. Is the patient intolerant or contraindicated to either methotrexate or leflunomide? Yes No
26. Has the patient had a trial of another nonbiologic DMARD for at least 3 consecutive months (e.g., hydroxychloroquine, cyclosporine, sulfasalazine, gold, azathioprine)? Yes No
27. Has the patient had an inadequate response to such therapy? Yes No
28. Is the patient intolerant or contraindicated to such therapy? Yes No
29. Was the patient adherent to prescribed therapy? Yes No
30. **Submit documentation** of last trial of nonbiologic DMARD.

Section B: Ankylosing Spondylitis

31. Does the patient have axial disease? Yes No **If no, skip to # 34*
32. Has the patient had a trial of at least one non-steroidal anti-inflammatory drug (NSAID) or COX-2 inhibitor for at least 3 consecutive months? Yes No **If no, skip to # 37*
33. Is the patient intolerant or contraindicated to NSAIDs and COX-2 inhibitors?
**Skip to # 39* Yes No
34. Does the patient have peripheral disease? Yes No
35. Has the patient had a trial of either methotrexate or sulfasalazine for at least 3 consecutive months?
**If yes, skip to # 37* Yes No

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Patient Name: _____ Patients Date of Birth: _____
Patients ID : _____

36. Is the patient intolerant or contraindicated to both methotrexate and sulfasalazine?
**Skip to # 39* Yes No

37. Has the patient had an inadequate response to prescribed therapy? Yes No

38. Was the patient adherent to prescribed therapies? Yes No

39. **Submit documentation** of last trial of conventional therapy unless contraindicated.

Section C: Polyarticular Juvenile Idiopathic Arthritis OR Psoriatic Arthritis

40. For diagnosis of polyarticular juvenile idiopathic arthritis ONLY, prior to therapy, did the patient's arthritis involve more than 4 joints? Yes No

41. Has the patient had a trial of either methotrexate or leflunomide for at least 3 consecutive months?
 Yes No **If no, skip to # 43*

42. Has the patient had an inadequate response to either methotrexate or leflunomide?
**Skip to # 47* Yes No

43. Is the patient intolerant or contraindicated to either methotrexate or leflunomide? Yes No

44. Has the patient had a trial of another nonbiologic DMARD for at least 3 consecutive months? PLEASE **CIRCLE WHICH ONE(S)** (e.g., hydroxychloroquine, cyclosporine, sulfasalazine, gold, azathioprine)
 Yes No

45. Has the patient had an inadequate response to such therapy? Yes No

46. Is the patient intolerant or contraindicated to such therapy? Yes No

47. Was the patient adherent to prescribed therapies? Yes No

48. **Submit documentation** of last trial of nonbiologic DMARD.

Section D: Plaque Psoriasis

49. What is the percentage of body surface area (BSA) affected? _____ %

50. Does the patient's psoriasis involve palms, soles, face and neck or genitalia? Yes No

51. Has the patient had a trial of ALL three of the following therapies for 3 consecutive months?
 Yes No **If no, skip to # 54*
 Topical treatment (e.g., calcipotriene, tazarotene, coal tar preparation, anthralin, medium to high potency corticosteroids)
 Phototherapy
 One systemic therapy (e.g., methotrexate, thioguanine, cyclosporine, acitretin)

52. Has the patient had an inadequate response to such therapies? Yes No

53. Was the patient adherent to each prescribed therapy? Yes No

54. Is the patient contraindicated or intolerant to such therapies? Yes No

55. **Submit documentation** of last trial of conventional therapy unless contraindicated.

Section E : Crohn's Disease

56. Has the diagnosis been made by a gastrointestinal or colorectal specialist? Yes No

57. Does the patient have fistulizing Crohn's? Yes, submit documentation No

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Patient Name: _____ Patients Date of Birth: _____
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58. Select ALL of the following drugs the patient is **intolerant** or **contraindicated** to:

- Azathioprine Mercaptopurine Corticosteroids
 Methotrexate Aminosalicylates Other _____

59. Select ALL of the following drugs the patient has **tried** or **had inadequate response** to:

- Azathioprine Mercaptopurine Corticosteroids
 Methotrexate Aminosalicylates Other _____

60. Has the patient been on such therapy for at least 3 consecutive months? Yes No

61. Does the patient have documentation of rapidly progressive disease-related symptoms while on conventional oral therapy? Yes, **submit documentation** No

62. Was the patient adherent to prescribed therapy? Yes No

63. Was the patient intolerant to prescribed conventional oral therapy? Yes No

64. **Submit documentation** of last trial of conventional therapy unless contraindicated.

****NOTE: We can NOT make a decision without a copy of the documentation - Thank You****

Information given on this form is accurate as of this date:

X _____

Prescriber or Authorized Signature

Date (mm/dd/yy)

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