PARAMOUNT
Affiliate of ProMedica

Criteria: STD
Approved: 11/2014
Verified: 12/2019
Reviewed:

Prior Authorization Criteria Form

This form applies to Paramount Commercial Members Only

Humira*

Complete/review information, sign and date. Please fax signed forms to Paramount at **1-844-256-2025**. You may contact Paramount by phone at **1-419-887-2520** with questions regarding the Prior Authorization process. When conditions are met, we will authorize the coverage of Humira*

Drug Name (select from list of drugs shown)

Humira (adalimumab) Other, Please specify

Quantity _____ **Frequency** _____ **Strength** _____

Route of Administration _____ **Expected Length of Therapy** _____

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician

Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Has the patient previously received the requested drug for one of the following conditions: A) Rheumatoid arthritis, B) Polyarticular juvenile idiopathic arthritis, C) Psoriatic arthritis, D) Ankylosing spondylitis, E) Axial spondyloarthritis, F) Crohn s disease, G) Ulcerative colitis, H) Plaque psoriasis, I) Hidradenitis suppurativa, J) Non-infectious intermediate, posterior or panuveitis? Y N
[If yes, no further questions.]

2. Is the requested drug prescribed for a patient with moderately to severely active rheumatoid arthritis (RA)? Y N
[If no, skip to question 4.]

3. Does the patient meet either of the following criteria: A) Patient has had an inadequate response, intolerance, or contraindication to methotrexate (MTX), or B) Patient has had an inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD (e.g., tofacitinib)? Y N
[No further questions.]

4. Is the requested drug prescribed for a patient with moderately to severely active polyarticular juvenile idiopathic arthritis? Y N
[If no, skip to question 6.]

5. Does the patient meet either of the following criteria: A) Patient has had an inadequate response, intolerance or contraindication to methotrexate (MTX), or B) Patient has had an inadequate response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD)? Y N
[No further questions.]

6. Is the requested drug prescribed for a patient with active psoriatic arthritis? Y N
[If yes, no further questions.]

7. Is the requested drug requested for a patient with active ankylosing spondylitis or axial spondyloarthritis? Y N
[If no, skip to question 9.]

8. Has the patient had an inadequate response to a non-steroidal anti-inflammatory drug (NSAID) trial OR has intolerance or contraindication to NSAIDs? Y N
[No further questions.]

9.Is the requested drug prescribed for a patient with moderate to severe chronic plaque psoriasis? Y N
[If no, skip to question 12.]

10. Does the patient meet one of the following criteria: A) At least 5 percent of body surface area was affected by plaque psoriasis at the time of diagnosis, or B) Crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) were affected by plaque psoriasis at the time of diagnosis? Y N
[If no, no further questions.]

11. Does the patient have an inadequate response, intolerance or contraindication to BOTH of the following: A) a three to four month trial of phototherapy, B) a three to four month trial of pharmacologic treatment with methotrexate, cyclosporine, or acitretin? Action Required: If Yes , attach office notes and clinical documentation for the response given. Y N
[No further questions.]

12. Is the requested drug prescribed for a patient with moderately to severely active Crohn s disease? Y N
[If no, skip to question 14.]

13. Does the patient meet either of the following criteria: A) Patient has had an inadequate response to at least one conventional therapy for Crohn s disease (e.g., corticosteroids, sulfasalazine, azathioprine, or mesalamine), or B) Patient has intolerance or a contraindication to conventional therapy? Y N
[No further questions.]

14. Is the requested drug prescribed for a patient with moderately to severely active ulcerative colitis? [If no, skip to question 16.]	Y	N
15. Does the patient meet either of the following criteria: A) Patient has had an inadequate response to at least one immunosuppressant therapy (e.g., corticosteroids, azathioprine, or 6-mercaptopurine), or B) Patient has intolerance or a contraindication to immunosuppressant therapy? [No further questions.]	Y	N
16. Is the requested drug prescribed for a patient with moderate to severe hidradenitis suppurativa? [If yes, no further questions.]	Y	N
17. Is the requested drug prescribed for a patient with non-infectious intermediate, posterior or panuveitis?	Y	N

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date