Health Partners Plans

# HEALTH PARTNERS MEDICARE
## *PRIOR AUTHORIZATION REQUEST FORM*

Humira - Medicare

**Phone: 215-991-4300** **Fax back to: 866-371-3239**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

**PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.**

| **Patient Name:** | **Prescriber Name:** | |
|---|---|---|
| Member Number: | Fax: | Phone: |
| Date of Birth: | Office Contact: | |
| Line of Business: □ Medicare | NPI: | State Lic ID: |
| Address: | Address: | |
| City, State ZIP: | City, State ZIP: | |
| Primary Phone: | Specialty/facility name (if applicable): | |

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:
Strength:
Directions / SIG:

**Please attach any pertinent medical history including labs and information for this member that may support approval.**

**Please answer the following questions and sign.**

Q1. Has the patient been evaluated for active or latent tuberculosis (TB) infection with a tuberculin skin test prior to the initiation of therapy?

☐ Yes ☐ No

Q2. Was the tuberculin skin test negative?

☐ Yes ☐ No

Q3. Has the patient received appropriate prophylaxis in accordance with Centers for Disease Control and Prevention (CDC) guidelines?

☐ Yes ☐ No

Q4. Is the patient being treated for any other active infection?

☐ Yes ☐ No

Q5. Humira is being prescribed by or in consultation with a:

☐ Rheumatologist
☐ Dermatologist
☐ Gastroenterologist
☐ Ophthalmologist
☐ Other - please describe in Additional Information

Q6. What is the patient's diagnosis?

☐ Rheumatoid arthritis or Psoriatic arthritis - Go to 7
☐ Plaque Psoriasis - Go to 8

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- ☐ Polyarticular juvenile idiopathic arthritis (JIA) - Go to 11
- ☐ Crohn's disease - Go to 12
- ☐ Ulcerative Colitis - Go to 13
- ☐ Hidradenitis Suppurativa - Go to 15
- ☐ Uveitis - Go to 17
- ☐ Other - Please define in Additional Information

Q7. Has the patient had an inadequate response, intolerance or contraindication to the trial of at least one or more disease modifying anti-rheumatic drugs (DMARDs) (e.g., azathioprine, hydroxychloroquine, D-penicillamine, sulfasalazine, methotrexate and non-steroidal anti-inflammatory drugs [NSAIDs])?
If Yes, go to 18.

☐ Yes ☐ No

Q8. For plaque psoriasis, is the disease moderate to severe?
If No, go to 10.

☐ Yes ☐ No

Q9. Has the patient had an inadequate response, intolerance or contraindication to methotrexate OR ultraviolet-B (UVB) therapy (alone or in combination with other medications) OR acitretin (requires prior authorization)?
If Yes, go to 23.

☐ Yes ☐ No

Q10. Does the patient have limited disease and had an inadequate response, intolerance or contraindication to one topical steroid (high to very high potency) AND calcipotriene 0.005% cream?
If Yes, go to 23.

☐ Yes ☐ No

Q11. Has the patient had an inadequate response, intolerance or contraindication to one or more disease modifying anti-rheumatic drugs (DMARDs) (e.g., non-steroidal anti-inflammatory drugs [NSAIDs], sulfasalazine, methotrexate, azathioprine, cyclosporine, or prednisone)?
If Yes, go to 21.

☐ Yes ☐ No

Q12. Has the patient had an inadequate response, intolerance or contraindication to corticosteroids and methotrexate or azathioprine, or infliximab?
If Yes, go to 20.

☐ Yes ☐ No

Q13. Has the patient had an inadequate response, intolerance or contraindication to corticosteroids, azathioprine, or 6-mercaptopurine (6-MP)?
If Yes, go to 14.

☐ Yes ☐ No

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Q14. Has the patient had inadequate response, intolerance or contraindication to infliximab? If Yes, go to 18.

☐ Yes ☐ No

Q15. For hidradenitis suppurativa, is the disease moderate to severe?

☐ Yes ☐ No

Q16. Has the patient had an inadequate response, intolerance or contraindication to the following: A) topical antibiotics (e.g., clindamycin), B) oral antibiotics (e.g., doxycycline, minocycline, amoxicillin-clavulanic acid, clindamycin, rifampin, dapsone), and C) intralesional triamcinolone injections?
If Yes, go to 19.

☐ Yes ☐ No

Q17. Has the patient had an inadequate response, intolerance or contraindication to one or more of the following: A) oral or topical glucocorticoids (prednisone, methylprednisone, prednisolone), B) immunosuppressive agents (azathioprine, methotrexate, cyclosporine), or C) periocular or intraocular injection (triamcinolone)?
If Yes, go to 22.

☐ Yes ☐ No

Q18. Is the patient 18 years of age or older?
If Yes, go to 23.

☐ Yes ☐ No

Q19. Is the patient 12 years of age or older?
If Yes, go to 23.

☐ Yes ☐ No

Q20. Is the patient 6 years of age or older?
If Yes, go to 23.

☐ Yes ☐ No

Q21. Is the patient 4 years of age or older?
If Yes, go to 23.

☐ Yes ☐ No

Q22. Is the patient 2 years of age or older?
If Yes, go to 23.

☐ Yes ☐ No

Q23. Additional Information:

Q24. Requested Duration:

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☐ 12 Months

Prescriber Signature

Date

2021 Medicare Prior Authorization Request