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. Does the patient have the diagnosis of rheumatoid arthritis or psoriatic arthritis?

☐ Yes ☐ No

Q2. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q3. Has the patient failed or had an inadequate response to the trial of at least one or more disease modifying anti-rheumatic drug (DMARD) OR is intolerant to DMARDs (e.g., azathioprine, hydroxychloroquine, D-penicillamine, sulfasalazine, methotrexate and non-steroidal anti-inflammatory drugs [NSAIDs])?

☐ Yes ☐ No

Q4. Does the patient have the diagnosis of plaque psoriasis?

☐ Yes ☐ No

Q5. Is the patient 18 years of age or older?

☐ Yes ☐ No

Q6. Is the disease moderate to severe?

☐ Yes ☐ No

Q7. Has the patient failed or had an inadequate response to a trial of methotrexate OR ultraviolet-B (UVB) therapy (alone or in combination with other medications) OR acitretin (requires prior authorization)?

☐ Yes ☐ No

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document

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:**

Q8. Has the patient failed or had an inadequate response to the trial of one topical steroid (high to very high potency) AND calcipotriene 0.005% cream?

☐ Yes ☐ No

Q9. Does the patient have the diagnosis of polyarticular juvenile idiopathic arthritis (JIA)?

☐ Yes ☐ No

Q10. Is the patient 4 years of age or older?

☐ Yes ☐ No

Q11. Has the patient failed or had an inadequate response to the trial of one or more disease modifying anti-rheumatic drug (DMARD) OR is intolerant to DMARDS (e.g., non-steroidal anti-inflammatory drugs [NSAIDs], sulfasalazine, methotrexate, azathioprine, cyclosporine, or prednisone)?

☐ Yes ☐ No

Q12. Does the patient have the diagnosis of Crohn's disease?

☐ Yes ☐ No

Q13. Is the patient 6 years of age or older?

☐ Yes ☐ No

Q14. Has the patient had an inadequate response, intolerance or contraindication to corticosteroids and methotrexate or azathioprine, or infliximab?

☐ Yes ☐ No

Q15. Does the patient have the diagnosis of ulcerative colitis?

☐ Yes ☐ No

Q16. Is the patient 5 years of age or older?

☐ Yes ☐ No

Q17. Has the patient had an inadequate response, intolerance or contraindication to corticosteroids, azathioprine, or 6-mercaptopurine (6-MP)?

☐ Yes ☐ No

Q18. Has the patient failed, lost response or been intolerant to infliximab?

☐ Yes ☐ No

Q19. Does the patient have the diagnosis of hidradenitis suppurativa?

☐ Yes ☐ No

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document

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:**

Q20. Is the patient 12 years of age or older?

☐ Yes ☐ No

Q21. Does the patient have moderate to severe disease?

☐ Yes ☐ No

Q22. Has the patient failed, had an inadequate response or been in tolerant 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?

☐ Yes ☐ No

Q23. Does the patient have the diagnosis of uveitis?

☐ Yes ☐ No

Q24. Is the patient 2 years of age or older?

☐ Yes ☐ No

Q25. Has the patient failed, had an inadequate response or been in tolerant 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)?

☐ Yes ☐ No

Q26. Is Humira being prescribed by or in consultation with a rheumatologist?

☐ Yes ☐ No

Q27. Is Humira being prescribed by or in consultation with a dermatologist?

☐ Yes ☐ No

Q28. Is Humira being prescribed by or in consultation with a gastroenterologist?

☐ Yes ☐ No

Q29. Is Humira being prescribed by or in consultation with an ophthalmologist?

☐ Yes ☐ No

Q30. 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

Q31. Was the tuberculin skin test negative?

☐ Yes ☐ No

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document

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:**

Q32. Has the patient received appropriate prophylaxis in accordance with Centers for Disease Control and Prevention (CDC) guidelines?

☐ Yes ☐ No

Q33. Is the patient being treated for any other active infection?

☐ Yes ☐ No

Q34. Additional Information:

Q35. Requested Duration:

☐ 12 Months

______________________________ Prescriber Signature

______________________________ Date

2021 Medicare Prior Authorization Request

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document