

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM
HUMIRA (adalimumab)

Patient name: _____ Medicaid or SS# _____
Physician Name: _____ Contact person: _____
Phone#: _____ Ext.and options _____ Fax# _____
Pharmacy _____ Pharmacy Phone#: _____
Diagnosis _____

All information to be legible, complete and correct or form will be returned

**FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF
MEDICAL NECESSITY TO (801) 536-0477**

CRITERIA:

Rheumatoid Arthritis, Psoriatic Arthritis, or Ankylosing Spondylitis:

- ▶ Diagnosis of severe Rheumatoid Arthritis, Psoriatic Arthritis
 - ▶ The number of swollen joints must be 6 or more (WRITE SPECIFIC NUMBER IN NOTES OR LETTER)
 - ▶ The number of tender joints must be 9 or more (WRITE SPECIFIC NUMBER IN NOTES OR LETTER)
- ▶ Diagnosis of Ankylosing Spondylitis
- ▶ History of treatment, incomplete response or intolerance to Methotrexate, NSAID'S and at least one other DMARD or second line drug (azathioprine, sulfasalazine, leflunomide, penicillamine, hydroxychloroquine, etc.) _____
- ▶ Absence of active bacterial or viral infection, malignancy, or immunosuppressive condition.
- ▶ Rheumatology consultation within the last 60 days.
- ▶ Humira may not be given with other biologic agents such as Interferon, experimental medications or combinations.

AUTHORIZATION:

Initial prior is for 12 weeks given every other week

RE-AUTHORIZATION:

Subsequent PA is for 12 months if the patient has at least 20% **DOCUMENTED** improvement in 4 of the following 6 areas: tender and swollen joint count, patient and or global assessment of disease activity, pain, acute phase reactants. Yearly letter updating response to Humira.