UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

# HUMIRA (adalimumab)for Crohn's Disease

Patient name:___________________________________Medicaid ID #:________________________________

Prescriber Name:_________________Prescriber NPI#:_____________ Contact person:____________________

Prescriber Phone#:___________________Extension/Option:________________ Fax#:___________________

Pharmacy:______________________Pharmacy Phone#:________________Pharmacy Fax #:_______________

Requested Medication:______________________________Strength:__________Frequency/Day:___________

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

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**FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF MEDICAL NECESSITY TO 855-828-4992** **note the new fax number**

**CRITERIA:**

- Age requirement: 18 years and older
- Diagnosis of moderate to severely active Crohn's Disease.
- Documented inadequate response to conventional therapy (i.e. 5-aminosalicylates, antibiotics, MTX, 6-mercaptopurine, azathioprine, coritcosteroids, or budesonide).

**OR**

- Documented intolerance to or loss of response on infliximab (Remicade).
- Negative TB skin test within the previous 12 months or history of treatment for latent TB infection.
- Absence of active bacterial or viral infection, malignancy, or immunosuppressive condition.
- Humira may not be given with other biologic agents such as Interferon, experimental medications or combination.

## AUTHORIZATION:

1 year

Initial prior is for one 6 –syringe starter pack and 2-syringe maintenance packs monthly thereafter.

## RE-AUTHORIZATION:

An updated letter of medical necessity or progress notes showing improvement with medication.

05/10/11

http://health.utah.gov/medicaid/pharmacy