

# Drug Coverage Review Request

Humira®



## SUPPLY ALL PRESCRIBER AND PATIENT INFORMATION

### PATIENT

MD First Name \_\_\_\_\_  
MD Last Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_  
Zip Code \_\_\_\_\_  
Phone \_\_\_\_\_  
Fax \_\_\_\_\_  
DEA number (optional) \_\_\_\_\_

### PATIENT

Cardholder ID # \_\_\_\_\_  
Patient Last Name \_\_\_\_\_  
Patient First Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_  
Zip Code \_\_\_\_\_  
Phone \_\_\_\_\_

Your patient's benefit plan requires that we review certain requests for coverage with the prescribing physician. This includes requests for benefit coverage beyond plan specifications. Please complete the following questions and then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the benefit plan's rules.

## SECTION A

### Please answer the following questions

- Yes  No Will the patient be receiving MORE THAN ONE biologic rheumatoid arthritis agent (*Enbrel, Kineret, Humira, Remicade, Orencia or Rituxan*) AT THE SAME TIME?
- Yes  No  Not Warranted Where warranted, will the patient be evaluated and screened for the presence of latent TB infection prior to initiation of therapy with this drug?
- For which indication is this drug being prescribed? (**please choose one primary indication**)
  - Moderate to severe rheumatoid arthritis (**please answer questions 4-11**)
  - Psoriatic arthritis (**please answer questions 4-11**)
  - Rapidly advancing, progressive rheumatoid arthritis (**please answer questions 10-11**)
  - Moderate to severe juvenile idiopathic arthritis (JIA)/juvenile rheumatoid arthritis (JRA) (**please answer question 20**)
  - Ankylosing spondylitis (**please answer questions 12-15**)
  - Induction or maintenance of remission in patients with moderate to severe Crohn's disease (**please answer questions 16-17**)
  - Moderate to severe plaque psoriasis (**please answer questions 18-19**)
  - Other

**Questions 4-11 apply only if diagnosis is moderate to severe rheumatoid arthritis or psoriatic arthritis**

- Yes  No Is the patient CURRENTLY RECEIVING this drug?
- Yes  No  Not Applicable If **Yes** to the **previous question**, has drug therapy provided SIGNIFICANT IMPROVEMENT in the patient's condition?
- Yes  No Will the patient be receiving THIS DRUG AND METHOTREXATE at the same time?
- Yes  No If **No** to the **previous question**, is the patient CURRENTLY RECEIVING methotrexate?
- Yes  No If the patient is not currently receiving methotrexate, has therapy with methotrexate FAILED TO TREAT the patient's condition?
- Yes  No Is the patient a CANDIDATE FOR RECEIVING methotrexate?

Please continue on Page 2



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Form # FL338635U

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10.  Yes  No Will the patient be receiving this drug at a dose of GREATER THAN 40 mg every other week (that is, at an increased dose of 40 mg once a week)?
11.  Yes  No If **Yes** to the **previous question**, has the patient had an inadequate response to this drug at the dose of 40 mg every OTHER week?

**Questions 12-15 apply only if diagnosis is *ankylosing spondylitis***

12.  Yes  No Has the patient received AT LEAST TWO OF THE FOLLOWING drugs: NSAIDs or a COX-2 inhibitor?
13.  Yes  No If **Yes** to the **previous question**, has the patient EXPERIENCED INADEQUATE SYMPTOM RELIEF from AT LEAST TWO NSAIDs and/or COX-2 Inhibitors?
14.  Yes  No Is the patient UNABLE TO RECEIVE drug therapy with NSAIDs or a COX-2 inhibitor?
15.  Yes  No Will the patient be receiving this drug at a dose of GREATER THAN 40 mg every other week (that is, at an increased dose of 40 mg once a week)?

**Questions 16-17 apply only if diagnosis is *induction or maintenance of remission in patients with moderate to severe Crohn's Disease***

16.  Yes  No Is this patient CURRENTLY RECEIVING this drug?
17.  Yes  No If **Yes** to the **previous question** will the patient be receiving this drug at a dose of GREATER THAN 40 mg every other week?

**Questions 18-19 apply only if the diagnosis is *moderate to severe plaque psoriasis***

18.  Yes  No Is this patient CURRENTLY RECEIVING this drug?
19.  Yes  No If **Yes** to the **previous question**, will the patient be receiving this drug at a dose of GREATER THAN 40 mg every other week?

**Question 20 applies only if diagnosis is *moderate to severe juvenile idiopathic arthritis (JIA)/juvenile rheumatoid arthritis (JRA)***

20.  Yes  No Will the patient be receiving this drug at a dose of GREATER THAN 40 mg every other week?

**SECTION B** Physician Signature

\_\_\_\_\_  
PHYSICIAN SIGNATURE

\_\_\_\_\_  
DATE

**FAX COMPLETED FORM TO: 1 800 837-0959**

PLEASE DO NOT FAX WITH A COVER SHEET

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