PRIOR AUTHORIZATION REQUEST FORM

Humana®

EOC ID:
Cytokines and CAM Antagonists 56
Phone: 1-800-555-2546 Fax to: 1-877-486-2621

Humana manages the pharmacy drug benefit for your patient. Certain requests for prior authorization require additional information from the prescriber. Please provide the following information and fax this form to the number listed above. **Information left blank or illegible may delay the review process.**

For Medicare Private-Fee-For-Service members, prior authorization is not required for medications covered under Part B. The information below is needed for a Part B versus Part D determination for these members.

Patient name:	**Prescriber name:**	
Member/subscriber number:	Fax:	Phone:
Patient date of birth:	Office contact:	
Group number:	NPI:	Tax ID:
Address:	Address:	
City, state, ZIP:	City, state, ZIP:	
	Specialty/facility name (if applicable):	

Drug name:

Directions/SIG:

Quantity:

☐ Expedited/exigent/urgent

By checking this box, I certify an expedited/exigent/urgent review is required. The member has a health condition that may seriously jeopardize his/her life or ability to regain maximum function**. (Please include explanation of exigency in the space below.)**

Is this a proactive request for a new plan year? Yes____ No____ If yes, please provide plan year:_____

(Please note: All reviews will be processed with generic equivalents for brand drugs whenever possible.)

Please attach pertinent medical history or information for this patient that may support approval and sign this form.

Q1. Please provide diagnosis: *

Q2. Please provide J-Code, if applicable:

Q3. Please provide ICD Diagnostic Codes:

Q4. Is the drug being requested one of the following: *

- ☐ Actemra
- ☐ Arcalyst
- ☐ Cimzia
- ☐ Entyvio
- ☐ Ilaris
- ☐ Ilumya
- ☐ Inflectra
- ☐ Kevzara
- ☐ Kineret
- ☐ Remicade
- ☐ Renflexis
- ☐ Rinvoq ER
- ☐ Siliq
- ☐ Simponi
- ☐ Simponi Aria
- ☐ Skyrizi
- ☐ Stelara
- ☐ Taltz

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☐ Olumiant
☐ Orencia
☐ Otezla
☐ Tremfya
☐ None of the above

Q5. Please indicate where the drug is being dispensed? *

☐ Pharmacy dispensed to patient
☐ Pharmacy shipped to prescriber
☐ Prescriber dispensed
☐ Other

Q6. If other, please specify: *

Q7. Please indicate if this request is a: *

☐ New start/ initial request ☐ Continuation/ reauthorization request

Q8. Does the patient have a clinical response to requested therapy? *

☐ Yes ☐ No

Q9. Is the drug requested part of a clinical trial?

☐ Yes ☐ No

Q10. If yes, please provide the registration or identification number for the specific trial for which this drug is being studied (e.g. ClinicalTrials.gov Identifier: NCT12345678): _____ *

Q11. Does the patient have a negative tuberculin test (TB) prior to initiating therapy? *

☐ Yes ☐ No

Q12. Is the patient 18 years of age or older? *

☐ Yes ☐ No

Q13. Does the patient have a diagnosis of Ankylosing Spondylitis? *

☐ Yes ☐ No

Q14. Has the patient had a trial, intolerance or contraindication to any of the following? (Please mark all that apply) *

☐ A trial at maximum dose for at least 2 – 3 weeks of one or more non-steroidal anti-inflammatory drugs (NSAIDs)
☐ Analgesic agents (acetaminophen or codeine)if NSAIDs do not completely control the pain
☐ Sulfasalazine (if peripheral joint involvement is present)
☐ At least one of the preferred drugs (e.g. Cosentyx, Enbrel, or Humira)

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☐ None of the above

Q15. Does the patient have a diagnosis of moderate to severe Crohn's Disease? *

☐ Yes ☐ No

Q16. Has the patient had a trial, intolerance or contraindication to any of the following? (Please mark all that apply) *

☐ Budesonide, mesalamine, or corticosteroids (e.g.prednisone or methylprednisolone)
☐ Humira
☐ Non-biologic DMARDs (e.g. azathioprine, methotrexate, mercaptopurine)
☐ None of the above

Q17. Does the patient have a diagnosis of moderate to severe plaque psoriasis of at least a six month duration? *

☐ Yes ☐ No

Q18. Do any of the following apply to the patient's diagnosis: (Please mark all that apply) *

☐ Incapacitation due to plaque location (e.g. head and neck, palms, or genitalia)
☐ Involvement of at least 10 percent of body surface area (BSA)
☐ Psoriasis Area and Severity Index (PASI) score of 12 or greater
☐ None of the above

Q19. Does the patient have any important active clinical infections? *

☐ Yes ☐ No

Q20. Has the patient had a minimum three month trial, intolerance or contraindication to any of the following: (Please mark all that apply) *

☐ Phototherapy (e.g. Psoralens with UVA light (PUVA) or UVB with coal tar or dithranol)
☐ Systemic agent (e.g. immunosuppresives, retinoic acid derivatives, and/or methotrexate)
☐ None of the above

Q21. Has the patient had a trial of at least one of the preferred drugs (e.g. Cosentyx, Enbrel, or Humira) and experienced inadequate response or intolerance? *

☐ Yes ☐ No

Q22. Does the patient have a diagnosis of active psoriatic arthritis for at least a six month duration? *

☐ Yes ☐ No

Q23. Do any of the following apply to the patient's diagnosis: (Please mark all that apply) *

☐ greater than or equal to three swollen joints
☐ greater than or equal to three tender joints
☐ none of the above

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Q24. Has the patient had a trial, intolerance or contraindication to any of the following? (Please mark all that apply) *

- ☐ A trial at maximum dose for at least 2 -3 weeks of one or more non-steroidal anti-inflammatory drugs (NSAIDs)
- ☐ One or more non-biologic disease modifying anti-rheumatic drugs (DMARDs) (e.g. methotrexate, sulfasalazine, leflunomide, cyclosporine)
- ☐ At least one of the preferred drugs (e.g. Cosentyx, Enbrel, Xeljanz IR or Humira)
- ☐ None of the above

Q25. Does the patient have a diagnosis of moderate to severe rheumatoid arthritis? *

☐ Yes ☐ No

Q26. Has the patient had a trial, intolerance or contraindication to any of the following? (Please mark all that apply) *

- ☐ One or more non-biologic DMARDs (e.g. methotrexate, leflunomide, sulfasalazine, hydroxychloroquine) for at least 3 consecutive months
- ☐ At least one of the preferred drugs (e.g. Enbrel, Humira, or Xeljanz IR)
- ☐ None of the above

Q27. Does the patient have a diagnosis of moderately to severely active ulcerative colitis (UC)? *

☐ Yes ☐ No

Q28. Has the patient had a trial, intolerance or contraindication to any of the following? (Please mark all that apply) *

- ☐ At least one of the preferred drugs (e.g. Humira or Xeljanz IR)
- ☐ Oral mesalamine
- ☐ Oral corticosteroids (e.g. prednisone, dexamethasone, methylprednisolone)
- ☐ Cyclosporine
- ☐ Azathioprine
- ☐ 6-mercaptopurine (6-MTP)
- ☐ Has demonstrated corticosteroid dependence
- ☐ None of the above

Q29. Does the patient have a diagnosis of juvenile idiopathic arthritis? *

☐ Yes ☐ No

Q30. Has the patient had a trial, intolerance or contraindication to any of the following: (Please mark all that apply) *

- ☐ Enbrel
- ☐ One or more non-steroidal anti-inflammatory (NSAIDs)
- ☐ One or more non-biologic DMARDs (e.g. methotrexate, sulfasalazine)
- ☐ None of the above

Q31. Does the patient have any of the following diagnoses:

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☐ Cryopyrin Associated Periodic Syndromes (CAPS): Muckle-Wells Syndrome, Familial Cold Autoinflammatory Syndrome, Neonatal-Onset Multisystem Inflammatory Disease / Chronic Infantile Neurological, Cutaneous, Articular Syndrome

☐ Tumor Necrosis Factor Receptor Associated Periodic Syndrome

☐ Hyperimmunoglobulin D Syndrome / Mevalonate Kinase Deficiency

☐ Familial Mediterranean Fever

☐ None of the above

Q32. Does the patient have a diagnosis of Polyarticular Juvenile Idiopathic Arthritis (PJIA)?

☐ Yes ☐ No

Q33. Has the patient had a trial, intolerance or contraindication to any of the following: (Please mark all that apply) *

☐ At least one of the preferred drugs (e.g. Enbrel or Humira)

☐ One or more non-steroidal anti-inflammatory (NSAIDs)

☐ One or more non-biologic DMARDs (e.g. methotrexate, sulfasalazine (in patients six and older))

☐ None of the above

Q34. Does the patient have a diagnosis of axial spondyloarthritis, non-radiographic with objective signs of inflammation? *

☐ Yes ☐ No

Q35. Has the patient had a trial, intolerance or contraindication to any of the following: (Please mark all that apply) *

☐ A trial at maximum dose for at least 2-3 weeks of one or more non-steroidal anti-inflammatory drugs (NSAIDs)

☐ Analgesic agents (acetaminophen or codeine) if NSAIDs do not completely control the pain

☐ None of the above

Q36. Does the patient have a diagnosis of oral ulcers associated with Behcet's disease? *

☐ Yes ☐ No

Q37. Has the patient have a trial, contraindication, or intolerance to any of the following (Please mark all that apply): *

☐ Triamcinolone oral paste

☐ Immunosuppressive agents (e.g. azathioprine, hydroxychloroquine, colchicine)

☐ None of the above

Q38. Additional comments:

Prescriber signature

Date

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