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Please note: All information below is required to process this request.

Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Humira® Prior Authorization Request Form (Page 1 of 2)

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Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information (required)					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if requesting brand			Directions for Use:		
<input type="checkbox"/> Check if request is for continuation of therapy					
Clinical Information (required)					
<p>Select the diagnosis below:</p> <p><input type="checkbox"/> Active ankylosing spondylitis</p> <p><input type="checkbox"/> Active psoriatic arthritis</p> <p><input type="checkbox"/> Moderate to severe chronic plaque psoriasis</p> <p><input type="checkbox"/> Moderate to severe hidradenitis suppurativa (i.e., Hurley Stage II or III)</p> <p><input type="checkbox"/> Moderately to severely active Crohn's disease</p> <p><input type="checkbox"/> Moderately to severely active polyarticular juvenile idiopathic arthritis (JIA)</p> <p><input type="checkbox"/> Moderately to severely active rheumatoid arthritis (RA)</p> <p><input type="checkbox"/> Moderately to severely active ulcerative colitis</p> <p><input type="checkbox"/> Uveitis (UV)</p> <p><input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____</p>					
<p>Prescriber's Specialty:</p> <p>Select if Humira is prescribed by or in consultation with one of the following specialists:</p> <p><input type="checkbox"/> Dermatologist <input type="checkbox"/> Gastroenterologist <input type="checkbox"/> Ophthalmologist <input type="checkbox"/> Rheumatologist</p>					
<p>For active ankylosing spondylitis, answer the following:</p> <p>Has the patient had trial and failure, contraindication, or intolerance to two non-steroidal anti-inflammatory drugs (NSAIDs)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>					
<p>For moderately to severely active Crohn's disease, answer the following:</p> <p>Select if the patient has had trial and failure, contraindication, or intolerance to the following conventional therapies:</p> <p><input type="checkbox"/> 6-mercaptopurine (Purinethol) <input type="checkbox"/> Corticosteroids (e.g., prednisone, methylprednisolone)</p> <p><input type="checkbox"/> Azathioprine (Imuran) <input type="checkbox"/> Methotrexate (Rheumatrex, Trexall)</p> <p>Has the patient had trial and failure (i.e., lost response) or intolerance to Remicade (infliximab)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>					
<p>For moderately to severely active polyarticular juvenile idiopathic arthritis (JIA), answer the following:</p> <p>Select if the patient has had trial and failure, contraindication, or intolerance to the following non-biologic disease modifying anti-rheumatic drugs (DMARDs):</p> <p><input type="checkbox"/> Arava (leflunomide)</p> <p><input type="checkbox"/> Methotrexate (Rheumatrex/Trexall)</p>					
<p>For moderately to severely active rheumatoid arthritis, answer the following:</p> <p>Has the patient had trial and failure, contraindication, or intolerance to one non-biologic disease modifying anti-rheumatic drug (DMARD) (e.g., methotrexate [Rheumatrex/Trexall], leflunomide [Arava], sulfasalazine [Azulfidine])? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>					

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Office use only: Humira_Comm_2019Mar-W



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For moderately to severely active ulcerative colitis, answer the following:

Select if the patient has had trial and failure, contraindication, or intolerance to the following conventional therapies:

- 6-mercaptopurine (Purinethol)
- Aminosalicylate (e.g., mesalamine [Asacol, Pentasa, Rowasa], olsalazine [Dipentum], sulfasalazine [Azulfidine, Sulfazine])
- Azathioprine (Imuran)
- Corticosteroids (e.g., prednisone, methylprednisolone)

For uveitis (UV), answer the following:

Does the patient have non-infectious uveitis? Yes No

Select the classification of uveitis:

- Intermediate
- Posterior
- Panuveitis

Reauthorization:

If this is a reauthorization request, answer the following questions:

Is there documentation the patient has had a positive clinical response to Humira therapy? Yes No

For moderately to severely active ulcerative colitis, also answer the following:

For patients who initiated Humira therapy within the past 12 weeks, is there documentation the patient has had clinical remission or significant clinical benefit by eight weeks (Day 57) of therapy? Yes No

For patients who have been maintained on Humira therapy for longer than 12 weeks, is there documentation the patient has had a positive clinical response to Humira therapy? Yes No

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note:

This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.