OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
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:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

- ❑ Ankylosing spondylitis (for example; M45.0; M45.9)
- ❑ Crohn's disease (for example; K50.00; K50.919; K50.019)
- ❑ Hidradenitis suppurativa (for example; L73.2)
- ❑ Plaque psoriasis (for example; psoriasis vulgaris; psoriasis; L40.0; L40.8; L40.9)
- ❑ Polyarticular juvenile idiopathic arthritis (for example; M08.09; M08.40)
- ❑ Psoriatic arthritis (for example; arthropathic psoriasis; L40.5; L40.59)
- ❑ Rheumatoid arthritis (for example; M05.79; M06.9)
- ❑ Ulcerative colitis (for example; ulcerative pancolitis; K51.00; K51.90; K51.919)
- ❑ Uveitis (for example; Iridocyclitis; H20; H20.9)
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Select if Humira is prescribed by or in consultation with one of the following specialist(s):

- ❑ Dermatologist
- ❑ Gastroenterologist
- ❑ Ophthalmologist
- ❑ Rheumatologist

For ankylosing spondylitis, also answer the following:

Is the patient's disease active? ❑ **Yes** ❑ **No**

Has the patient had a trial and failure, contraindication, or intolerance to TWO non-steroidal anti-inflammatory drugs (NSAIDs)? ❑ **Yes** ❑ **No**

For Crohn's disease, also answer the following:

Is the patient's disease moderately to severely active? ❑ **Yes** ❑ **No**

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

- ❑ 6-mercaptopurine
- ❑ Azathioprine (Imuran)
- ❑ Corticosteroid (e.g., prednisone, methylprednisolone)
- ❑ Methotrexate (Rheumatrex, Trexall)

Has the patient had a trial and failure (i.e., lost response) or intolerance to infliximab? ❑ **Yes** ❑ **No**

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For hidradenitis suppurativa, also answer the following:

Is the patient's disease moderate to severe (that is, Hurley Stage II or III)? ❑ **Yes** ❑ **No**

For plaque psoriasis, also answer the following:

Is the patient's disease chronic and moderate to severe? ❑ **Yes** ❑ **No**

For polyarticular juvenile idiopathic arthritis (JIA), also answer the following:

Is the patient's disease moderately to severely active? ❑ **Yes** ❑ **No**

Has the patient had a trial and failure, contraindication, or intolerance to Arava (leflunomide) **OR** Rheumatrex/Trexall (methotrexate)? ❑ **Yes** ❑ **No**

For psoriatic arthritis, also answer the following:

Is the patient's disease active? ❑ **Yes** ❑ **No**

For rheumatoid arthritis (RA), also answer the following:

Is the patient's disease moderately to severely active? ❑ **Yes** ❑ **No**

Has the patient had a trial and failure, contraindication, or intolerance to one disease modifying anti-rheumatic drug (DMARD) [e.g., methotrexate (Rheumatrex/Trexall), leflunomide (Arava), sulfasalazine (Azulfidine)]? ❑ **Yes** ❑ **No**

For ulcerative colitis, also answer the following:

Is the patient's disease moderately to severely active? ❑ **Yes** ❑ **No**

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

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

For uveitis, also answer the following:

Is the patient's disease non-infectious? ❑ **Yes** ❑ **No**

Select the patient's uveitis classification:

- ❑ Intermediate
- ❑ Panuveitis
- ❑ Posterior

Reauthorization:

If this is a reauthorization request, answer the following:

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

For ulcerative colitis, also answer the following:

For patients who initiated Humira therapy within the past 12 weeks: Is there documentation the patient has experienced clinical remission or significant clinical benefit by eight weeks (Day 57) of 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.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-844-403-1028.