

**Adalimumab-fkjp 20mg/0.4ml**  
**Prior Authorization Request Form**

Caterpillar Prescription Drug Benefit  
Phone: 877-228-7909 Fax: 800-424-7640

**MEMBER'S LAST NAME:** \_\_\_\_\_ **MEMBER'S FIRST NAME:** \_\_\_\_\_

**Instructions:** Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

**URGENT**

MEMBER INFORMATION	
<b>LAST NAME:</b>	<b>FIRST NAME:</b>
<b>PHONE NUMBER:</b>	<b>DATE OF BIRTH:</b>
<b>STREET ADDRESS:</b>	
<b>CITY:</b>	<b>STATE:</b> <b>ZIP CODE:</b>
<b>PATIENT INSURANCE ID NUMBER:</b>	

**MALE**     **FEMALE**    **HEIGHT (IN/CM):** \_\_\_\_\_    **WEIGHT (LB/KG):** \_\_\_\_\_    **ALLERGIES:** \_\_\_\_\_

**IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: [PRIMETHERAPEUTICS.COM/NOPP](http://PRIMETHERAPEUTICS.COM/NOPP)**

**PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE):** \_\_\_\_\_  
**AUTHORIZED REPRESENTATIVE'S PHONE NUMBER:** \_\_\_\_\_

PRESCRIBER INFORMATION	
<b>LAST NAME:</b>	<b>FIRST NAME:</b>
<b>PRESCRIBER SPECIALTY:</b>	<b>EMAIL ADDRESS:</b>
<b>NPI NUMBER:</b>	<b>DEA NUMBER:</b>
<b>PHONE NUMBER:</b>	<b>FAX NUMBER:</b>
<b>STREET ADDRESS:</b>	
<b>CITY:</b>	<b>STATE:</b> <b>ZIP CODE:</b>
<b>REQUESTER (if different than prescriber):</b>	<b>OFFICE CONTACT PERSON:</b>

MEDICATION OR MEDICAL DISPENSING INFORMATION			
<b>MEDICATION NAME:</b>			
<b>DOSE/STRENGTH:</b>	<b>FREQUENCY:</b>	<b>LENGTH OF THERAPY/REFILLS:</b>	<b>QUANTITY:</b>
<input type="checkbox"/> <b>NEW THERAPY</b> <input type="checkbox"/> <b>RENEWAL</b> <b>IF RENEWAL: DATE THERAPY INITIATED:</b>			
<b>DURATION OF THERAPY (SPECIFIC DATES):</b>			

*Continued on next page*

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**1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION?**

YES (if yes, complete below)  NO

MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	DURATION OF THERAPY (SPECIFY DATES):	RESPONSE/REASON FOR FAILURE/ALLERGY:

**2. LIST DIAGNOSES:**

**ICD-10:**

- Ankylosing spondylitis
- Crohn's disease
- Hidradenitis suppurativa
- Juvenile idiopathic arthritis (JIA)
- Non-infectious uveitis
- Plaque psoriasis
- Psoriatic arthritis
- Pyoderma gangrenosum
- Rheumatoid arthritis
- Ulcerative colitis
- Chronic Recurrent Multifocal Osteomyelitis(CRMO)
- Other diagnosis: \_\_\_\_\_
- Other diagnosis: \_\_\_\_\_ ICD-10 Code(s): \_\_\_\_\_

**3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.**

Is patient going to be using drug in combination with a clinical trial?  Yes  No

Will adalimumab-aacf be used in combination with another biologic response modifier [such as but not limited to: Kineret (anakinra), Rituxan (rituximab), Remicade (infliximab), Orencia (abatacept), Cimzia (certolizumab pegol), Enbrel (etanercept), Simponi (golimumab), Actemra (tocilizumab)], Xeljanz (tofacitinib), Rinvoq (upadacitinib), Olumiant (baricitinib), Cibinqo (abrocitinib)?  Yes  No

Select if the requested medication is prescribed by the following specialist:

- Dermatologist
- Gastroenterologist
- Ophthalmologist
- Rheumatologist

For ankylosing spondylitis, also answer the following:

Has the patient had adequate trial and failure to at least TWO (2) non-steroidal anti-inflammatory agents (NSAIDs)?  Yes  No

Please document the two NSAIDs tried:

\_\_\_\_\_

Are non-steroidal anti-inflammatory agents (NSAIDs) contraindicated in this patient?  Yes  No

Please provide documentation.

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Has the patient had a trial of methotrexate?  Yes  No Please provide documentation.

For Crohn's disease, also answer the following:

Select if the patient has had a trial of the following:\*

- 5-ASA/mesalamine
- 6-mercaptopurine
- Azathioprine
- Glucocorticoid therapy
- Methotrexate

*\*Please provide supporting chart notes for verification*

Is there clinical rationale explaining why the patient cannot try glucocorticoid therapy, methotrexate, azathioprine, 6-mercaptopurine or 5-ASA/mesalamine?  Yes  No *\*Please provide supporting documentation.*

For hidradenitis suppurativa, also answer the following:

Is the medication being used prior to surgery?  Yes  No

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

Has the patient had a trial and inadequate response to therapy with oral disease modifying anti-rheumatic agents (DMARDs) [e.g., methotrexate, azathioprine (Imuran), auranofin (Ridaura), hydroxychloroquine (Plaquenil), sulfasalazine (Azulfidine), leflunomide (Arava)]?  Yes  No *\*Please submit chart documentation on therapies the patient has tried.*

Does the patient have chronic liver disease such as chronic alcohol abuse/alcoholism, chronic hepatitis, fatty liver, nonalcoholic steatohepatitis/NASH, or elevated liverenzymes?  Yes  No Please provide documentation.

Is there clinical rationale explaining why the patient cannot try a DMARD?  Yes  No

*\*Please provide supporting documentation.*

For non-infectious uveitis, also answer the following:

Does the patient have isolated anterior uveitis?  Yes  No Please provide documentation.

For plaque psoriasis, also answer the following:

Does the patient have plaques covering at least 10% of their body surface area (BSA) or < 10% of BSA, but with involvement of palms, soles, head and neck, or genitalia which causes disruption of normal activities?  Yes  No Please provide documentation.

Select if patient has had previous treatment failure with any of the following:

- Acitretin
- Cyclosporine
- Methotrexate
- Phototherapy

*\*Please submit what therapies the patient has tried.*

Is there clinical rationale explaining why the patient cannot try any of the following: methotrexate, cyclosporine, acitretin, or phototherapy?  Yes  No

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*\*Please provide supporting documentation.*

For psoriatic arthritis, also answer the following:

Has the patient had a trial and inadequate response to therapy with oral disease modifying anti-rheumatic agents (DMARDs) [e.g., methotrexate, azathioprine (Imuran), auranofin (Ridaura), hydroxychloroquine (Plaquenil), penicillamine (Cuprimine), sulfasalazine (Azulfidine), leflunomide (Arava)]?  Yes  No

*\*Please submit chart documentation on therapies the patient has tried.*

Does the patient have chronic liver disease such as chronic hepatitis, fatty liver, nonalcoholic steatohepatitis/NASH, or elevated liver enzymes?  Yes  No Please provide documentation.

Is there clinical rationale explaining why the patient cannot try a DMARD?  Yes  No

*\*Please provide supporting documentation*

For pyoderma gangrenosum, also answer the following:

Has the patient had a trial of glucocorticoid therapy?  Yes  No

*Please provide supporting chart notes.*

Select if the patient has had a trial of the following systemic therapies:

- Azathioprine  Dapsone  Nicotine
- Chlorambucil  Hyperbaric oxygen  Tacrolimus
- Cyclophosphamide  Intravenous immune globulin  Thalidomide
- Cyclosporine  Mycophenolate

Is there clinical rationale explaining why the patient cannot try corticosteroids and one additional systemic therapy (such as cyclosporine, mycophenolate, dapsone, azathioprine, etc.)?  Yes  No

*\*Please provide supporting documentation.*

For rheumatoid arthritis, also answer the following:

Has the patient had a trial with methotrexate or another oral disease modifying anti-rheumatic agent (DMARD)

such as azathioprine (Imuran), auranofin (Ridaura), hydroxychloroquine (Plaquenil), sulfasalazine (Azulfidine), or leflunomide (Arava)?  Yes  No

*\*Please submit chart documentation on therapies the patient has tried.*

Does the patient have chronic liver disease such as chronic alcohol abuse/alcoholism chronic hepatitis, fatty liver, nonalcoholic steatohepatitis/NASH, or elevated liver enzymes?  Yes  No Please provide documentation.

Is the patient unable to take a non-biologic DMARD due to patient is a male of fatherhood potential or a female of childbearing potential?  Yes  No Please provide documentation.

If "no" to the above question, provide the rationale explaining why the patient cannot take the prerequisite non-biologic DMARDs:

\_\_\_\_\_

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**For ulcerative colitis, also answer the following:**

Select if the patient has tried and failed at least one of the following therapies:

- Corticosteroids
- Azathioprine
- 6-mercaptopurine

*\*Please provide supporting chart notes.*

Is there clinical rationale explaining why the patient cannot try corticosteroids, azathioprine, or 6-mercaptopurine?\*  Yes  No

*\*Please provide supporting documentation.*

**For chronic recurrent multifocal osteomyelitis(CRMO):**

Has patient tried and failed at least 2 types of non-steroidal anti-inflammatory agents?  Yes  No

Please submit documentation.

Has patient tried and failed a bisphosphonate?  Yes  No Please submit documentation.

Does patient have an absolute contraindication to a bisphosphonate?  Yes  No Please submit documentation.

Has patient tried and failed some kind of DMARD such as methotrexate or corticosteroids?  Yes  No Please submit documentation.

Does patient have an absolute contraindication to DMARDs?  Yes  No Please submit documentation.

Does patient have spinal involvement?  Yes  No Please submit documentation.

**Reauthorization:**

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

Select if the requested medication is prescribed by the following specialist:

- Dermatologist
- Gastroenterologist
- Ophthalmologist
- Rheumatologist

Will adalimumab-aacf be used in combination with another biologic response modifier [such as but not limited to: Kineret (anakinra), Rituxan (rituximab), Remicade (infliximab), Orencia (abatacept), Cimzia (certolizumab pegol), Enbrel (etanercept), Simponi (golimumab), Actemra (tocilizumab)], Xeljanz (tofacitinib), Rinvoq(upadacitinib), Olumiant(baricitinib), Cibinqo(abrocitinib)?  Yes  No

**For all indications except non-infectious uveitis, also answer the following:**

Is the patient continuing to have a positive clinical response and remission of disease?\*  Yes  No

*\*Please provide documentation supporting this information.*

**For non-infectious uveitis, also answer the following:**

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**Has the patient 's response been evaluated at a recent office visit (i.e., occurring after previous date of approval)?\***  Yes  No

*\*Please provide progress notes/chart notes from the patient's ophthalmologist or rheumatologist supporting this information.*

**Has the patient had a positive response to therapy?**  Yes  No **Please provide documentation.**

**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:** Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

**ATTESTATION:** I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

**Prescriber Signature or Electronic I.D. Verification:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**CONFIDENTIALITY NOTICE:** The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

**FAX THIS FORM TO:** 800-424-7640

**MAIL REQUESTS TO:** Prime Therapeutics Management Prior Authorization Program

Attn: CP-4201

P.O. Box 64811

St. Paul, MN 55164-0811

**Phone:** 877-228-7909