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		
LAST NAME:	**FIRST NAME:**	
PHONE NUMBER:	**DATE OF BIRTH:**	
STREET ADDRESS:		
CITY:	**STATE:**	**ZIP CODE:**
PATIENT INSURANCE ID NUMBER:		

☐ **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

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

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

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** **IF RENEWAL:** DATE THERAPY INITIATED: DURATION OF THERAPY (SPECIFIC DATES):			

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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** ☐ **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 <u>ankylosing spondylitis,</u> 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.

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

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 **□ Methotrexate**
□ Cyclosporine **□ 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
Please provide supporting documentation.

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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 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 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:
_____

For ulcerative colitis, also answer the following:

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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.

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 with continued use of Humira?* □ **Yes** □ **No**
Please provide documentation supporting this information.

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

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Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

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