PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Humira (Uveitis)

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. What drug is being requested?

- ☐ Humira 40 MG/0.8 ML PEN (GCN 97005)
- ☐ Humira 40 MG/0.8 ML SYRINGE (GCN 18924)
- ☐ Humira PEN CROHN-UC-HS 40 MG (GCN 97005)
- ☐ Humira PEN PSORIA-UVEITIS 40MG (GCN 97005)
- ☐ Humira 40 MG/0.4 ML PEN Citrate free/Low volume (GCN 43506)
- ☐ Humira 40 MG/0.4 ML SYRINGE Citrate free/Low volume (GCN 43505)
- ☐ Humira PEN CROHN-UC-HS 80 MG Citrate free/Low volume (GCN 44014)
- ☐ Humira PEN PSOR-UVEI 80MG-40MG Citrate free/Low volume (GCN 44954)
- ☐ Other (Please specify)

Q2. What are the quantity and days supply requested?

Q3. For what indication is this drug being prescribed?

- ☐ Non-infectious intermediate, posterior, and panuveitis
- ☐ Other (Please specify)

Q4. Please provide ICD code(s) for diagnosis.

Q5. Is the patient a new start to therapy? If no, please provide start date.

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☐ Yes	☐ No

Q6. Specify the prescriber's specialty.

- ☐ Ophthalmologist
- ☐ Rheumatologist
- ☐ Other (please specify)

Q7. Does the patient have failure of an adequate trial of, clinically significant intolerance, or contraindication to systemic corticosteroids?

☐ Yes	☐ No

Q8. Does the patient have active inflammation despite 3 month or more trial of a steroid sparing agent (methotrexate, azathioprine, mycophenolate, cyclosporine, tacrolimus)?

☐ Yes	☐ No

Q9. Who is the ENTITY that will be submitting the CLAIM for the DRUG and seeking reimbursement?

- ☐ Pharmacy
- ☐ Individual prescriber
- ☐ Provider or specialty group
- ☐ Facility
- ☐ Other (please specify)

Q10. Provide name and NPI of the billing entity

Q11. Will the claim for the drug be submitted as a MEDICAL claim or PHARMACY claim (Note: If a pharmacy will be submitting a MEDICAL claim for drug reimbursement, answer MEDICAL)?

☐ Medical	☐ Pharmacy

Q12. Additional Comments

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Prescriber Signature

Date

□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to a SWHP pharmacist or medical director at 1-800-728-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.