**PRIOR AUTHORIZATION REQUEST FORM**

# Medicare Part D - Humira

**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:**<br>**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 diagnosis is this drug being prescribed for (pick one)?

- ☐ Plaque Psoriasis
- ☐ Psoriatic Arthritis
- ☐ Ankylosing Spondylitis
- ☐ Rheumatoid Arthritis
- ☐ Juvenile Idiopathic Arthritis
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis
- ☐ Hidradenitis Suppurativa
- ☐ Uveitis
- ☐ Other

Q2. Please provide ICD code for diagnosis.

Q3. Is the prescriber a Rheumatologist?

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|---|---|

☐ Yes ☐ No

Q4. Is the prescriber a Dermatologist?

☐ Yes ☐ No

Q5. Is the prescriber a Gastroenterologist?

☐ Yes ☐ No

Q6. Is the prescriber an Ophthalmologist?

☐ Yes ☐ No

Q7. If request is for plaque psoriasis, does the patient have moderate to severe plaque psoriasis affecting greater than 5% of the body surface area or affecting crucial body areas such as hands, feet, face, or genitals?

☐ Yes ☐ No

Q8. If request is for plaque psoriasis, has the patient failed or does the patient have a contraindication to at least TWO of the following: potent topical corticosteroids, calcipotriene, tazarotene, phototherapy, acitretin, methotrexate, or cyclosporine.

☐ Yes (Please Specify) ☐ No

Q9. If using for rheumatoid arthritis, does the patient have failure, intolerance, or contraindication to methotrexate?

☐ Yes ☐ No

Q10. Additional comments

_____ _____

Prescriber Signature Date

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□ 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