

**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.

<b>Patient Name:</b>	<b>Prescriber Name:</b>
Member/Subscriber Number:	<b>Supervising Physician:</b>
Date of Birth:	Fax: Phone:
Group Number:	Office Contact:
Address:	NPI: State Lic ID:
City, State ZIP:	Address:
Primary Phone:	City, State ZIP:
	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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<b>Patient Name:</b>	<b>Prescriber Name: Supervising Physician:</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Q4. Is the prescriber a Dermatologist? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q5. Is the prescriber a Gastroenterologist? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q6. Is the prescriber an Ophthalmologist? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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. <input type="checkbox"/> Yes (Please Specify) <input type="checkbox"/> No	
Q9. If using for rheumatoid arthritis, does the patient have failure, intolerance, or contraindication to methotrexate? <input type="checkbox"/> Yes <input type="checkbox"/> 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

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