aetna®

# Humira® (adalimumab) Injectable Medication Precertification Request



(All fields must be completed and legible for Precertification Review.)

**Aetna Precertification Notification**
**Phone:** 1-855-240-0535
**FAX:** 1-877-269-9916

**For Medicare Advantage Part B:**
FAX: 1-844-268-7263

**Please indicate:** ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

**Precertification Requested By:** _____ Phone: _____ Fax: _____

## A. PATIENT INFORMATION

| | | | |
|---|---|---|---|
| First Name: | Last Name: | | |
| Address: | City: | State: | ZIP: |
| Home Phone: | Work Phone: | Cell Phone: | |
| DOB: | Allergies: | Email: | |

Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms

## B. INSURANCE INFORMATION

**Aetna Member ID #**: _____
**Group #**: _____
**Insured**: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured: _____

**Medicare**: ☐ Yes ☐ No If yes, provide ID #: _____ **Medicaid**: ☐ Yes ☐ No If yes, provide ID #: _____

## C. PRESCRIBER INFORMATION

| | | | | | |
|---|---|---|---|---|---|
| First Name: | | Last Name: *(Check One)*: ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A. | | | |
| Address: | | City: | | State: | ZIP: |
| Phone: | Fax: | St Lic #: | NPI #: | DEA #: | UPIN: |
| Provider Email: | | Office Contact Name: | | Phone: | |

**Specialty** *(Check one)*: ☐ **Dermatologist** ☐ **Gastroenterologist** ☐ **Rheumatologist** ☐ **Other**: _____

## D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

**Place of Administration:**
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

**Dispensing Provider/Pharmacy:** *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order
☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
**TIN:** _____ PIN: _____

## E. PRODUCT INFORMATION

**Request is for Humira (adalimumab): Dose:** _____ **Frequency:** _____

## F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

## G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

**For Initiation requests (clinical documentation required for all requests):**

☐ Yes ☐ No Will Humira (adalimumab) be used concomitantly with apremilast, tofacitinib, or other biologic DMARDs (e.g., etanercept, infliximab)?

☐ Yes ☐ No Has the patient been tested for TB with a PPD test, interferon-release assay (IGRA) or chest x-ray within 6 months of initiating a biologic therapy?
(check all that apply): ☐ PPD test ☐ interferon-gamma assay (IGRA) ☐ chest x-ray
→ Please enter the results of the TB test: ☐ Positive ☐ Negative ☐ Unknown
***If positive,*** Does the patient have latent or active TB? ☐ Latent ☐ Active
***If latent TB,*** ☐ Yes ☐ No Will TB treatment be started before initiation of therapy with Humira (adalimumab)?

**Ankylosing Spondylitis**

☐ Yes ☐ No Is there evidence that the disease is active?

☐ Yes ☐ No Has the patient had an ineffective response to two or more non-steroidal anti-inflammatory drugs (NSAIDs)?
→ Please provide the names and length of treatment:
NSAID #1: _____
Please indicate the length of treatment: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater
NSAID #2: _____
Please indicate the length of treatment: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

How many of the following medications have been ineffective, not tolerated, or contraindicated: Enbrel (etanercept), Inflectra (infliximab-dyyb), Remicade (infliximab), Renflexis (infliximab-abda), Simponi (golimumab)?
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

Please indicate the ***first*** medication that has been ineffective, not tolerated, or contraindicated:
☐ Enbrel (etanercept) ☐ Inflectra (infliximab-dyyb) ☐ Remicade (infliximab) ☐ Renflexis (infliximab-abda) ☐ Simponi (golimumab)
Was treatment ineffective, not tolerated, or contraindicated? ☐ ineffective ☐ not tolerated ☐ contraindicated
Please indicate the length of the first medication trial: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

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| Patient First Name | Patient Last Name | Patient Phone | Patient DOB |
|---|---|---|---|
| | | | |

**G. CLINICAL INFORMATION (*continued*)** – Required clinical information must be completed in its entirety for all precertification requests.

Please indicate the ***second*** medication that has been ineffective, not tolerated, or contraindicated:
☐ Enbrel (etanercept) ☐ Inflectra (infliximab-dyyb) ☐ Remicade (infliximab) ☐ Renflexis (infliximab-abda) ☐ Simponi (golimumab)
Was treatment ineffective, not tolerated, or contraindicated? ☐ ineffective ☐ not tolerated ☐ contraindicated
Please indicate the length of the second medication trial: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

**Bechet's Uveitis**

☐ Yes ☐ No Is the disease refractory?

**Crohn's Disease**

☐ Yes ☐ No Does the patient have a diagnosis of fistulizing Crohn's disease?
→ Please indicate how long the patient has been diagnosed with fistulizing Crohn's disease:
Please select: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

☐ Yes ☐ No Does the patient have a diagnosis of Crohn's disease?
What is the severity of the patient's Crohn's disease? ☐ Mild ☐ Moderate ☐ Severe

☐ Yes ☐ No Does the patient have a documented diagnosis of active Crohn's disease?
→ Please select all signs/symptoms that apply:
☐ abdominal pain ☐ arthritis ☐ bleeding ☐ diarrhea ☐ internal fistulae ☐ intestinal obstruction
☐ megacolon ☐ perianal disease ☐ spondylitis ☐ weight loss ☐ None of the above

☐ Yes ☐ No Have the Crohn's disease symptoms remained active despite treatment with either 6-mercaptopurine, azathioprine, or corticosteroids?
Please check all medications that apply: ☐ 6-mercaptopurine ☐ azathioprine ☐ corticosteroids
→ Please indicate the length of the medication trial: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

☐ Yes ☐ No Has treatment with any of the following have been ineffective, not tolerated, or contraindicated: Entyvio (vedolizumab), Inflectra (infliximab-dyyb), Remicade (infliximab), Stelara (ustekinumab)?
→ Check all that apply: ☐ Entyvio (vedolizumab) ☐ Inflectra (infliximab-dyyb) ☐ Remicade (infliximab) ☐ Stelara (ustekinumab)
Please indicate the length of the medication trial: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater
Was treatment ineffective, not tolerated, or contraindicated? ☐ ineffective ☐ not tolerated ☐ contraindicated

**Hidradenitis suppurativa**

Please indicate the stage of hidradenitis suppurativa: ☐ Hurley stage I (mild disease) ☐ Hurley stage II (moderate disease) ☐ Hurley stage III (severe disease) ☐ Unknown

☐ Yes ☐ No Has the patient completed a trial of antibiotics?
→ ☐ Yes ☐ No Does the patient have a contraindication to oral antibiotics?
→ ☐ Yes ☐ No Was the treatment with antibiotics ineffective?
Please indicate the length of the medication trial: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months (90 days) or greater

**Juvenile idiopathic arthritis (juvenile rheumatoid arthritis)**

What is the severity of the patient's disease? ☐ Mild ☐ Moderate ☐ Severe

☐ Yes ☐ No Is there evidence that the disease is active?

☐ Yes ☐ No Does the patient have clinical documentation of polyarticular juvenile idiopathic arthritis (JRA)?

☐ Yes ☐ No Was treatment with Enbrel (etanercept) ineffective?
→ Please indicate the length of the medication trial: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

☐ Yes ☐ No Does the patient have a documented intolerance to Enbrel (etanercept)?

☐ Yes ☐ No Does the patient have a documented contraindication to Enbrel (etanercept)?

**Noninfectious uveitis**

☐ Yes ☐ No Was the treatment with corticosteroids ineffective?
→ Please indicate the corticosteroid name: _____
Please indicate the length of the medication trial: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

☐ Yes ☐ No Was the treatment with immunosuppressive drugs (e.g., azathioprine, cyclosporine, or methotrexate) ineffective?
→ Please indicate the immunosuppressive name: _____
Please indicate the length of the medication trial: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

☐ Yes ☐ No Does the patient have a documented intolerance to corticosteroids or immunosuppressive drugs?
→ Please indicate the drug(s) the patient has intolerance to: ☐ corticosteroids ☐ immunosuppressive drugs

☐ Yes ☐ No Does the patient have a documented contraindication to corticosteroids or immunosuppressive drugs?
→ Please indicate the drug(s) the patient has contraindication to: ☐ corticosteroids ☐ immunosuppressive drugs

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**G. CLINICAL INFORMATION (*continued*)** – Required clinical information must be completed in its entirety for all precertification requests.

**Plaque Psoriasis**

What is the severity of the patient's disease? ☐ Mild ☐ Moderate ☐ Severe

☐ Yes ☐ No Is there evidence that the disease is active?

☐ Yes ☐ No Is there clinical documentation of chronic disease?

☐ Yes ☐ No Is the patient a candidate for systemic therapy or phototherapy?

→ Please select: ☐ phototherapy ☐ systemic therapy ☐ phototherapy and systemic therapy

Please provide the patient's Psoriasis Area and Severity Index (PASI) score: _____

Please indicate the percentage of body surface area affected by plaque psoriasis: _____%

☐ Yes ☐ No Does the plaque psoriasis involve sensitive areas? ***If yes***, please select: ☐ hands ☐ feet ☐ face ☐ genitals

☐ Yes ☐ No Was the trial with systemic conventional DMARD(s) (e.g., methotrexate, acetretin, or cyclosporine) ineffective?

→ ☐ Yes ☐ No Was the trial with systemic conventional DMARD(s) not tolerated?

☐ Yes ☐ No Are systemic conventional DMARDs contraindicated?

→ Provide the name: _____

Please indicate the length of the medication trial: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

☐ Yes ☐ No Was the trial with phototherapy ineffective?

→ ☐ Yes ☐ No Was the trial with phototherapy not tolerated?

☐ Yes ☐ No Is phototherapy contraindicated?

→ Please check all that apply: ☐ Psoralens (methoxsalen, trioxsalen) with UVA light (PUVA)

☐ UVB with coal tar or dithranol

☐ UVB (standard or narrow-band)

☐ Home UVB

Please indicate the length of the trial: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

How many of the following medications have been ineffective, not tolerated, or contraindicated Enbrel (etanercept), Inflectra (infliximab-dyyb), Otezla (apremilast), Remicade (infliximab), Renflexis (infliximab-abda), Stelara (ustekinumab), Tremfya (guselkumab)?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

Please indicate the ***first*** medication that has been ineffective, not tolerated, or contraindicated:

☐ Enbrel (etanercept) ☐ Inflectra (infliximab-dyyb) ☐ Otezla (apremilast) ☐ Remicade (infliximab) ☐ Renflexis (infliximab-abda)
☐ Stelara (ustekinumab) ☐ Tremfya (guselkumab)

Was treatment ineffective, not tolerated, or contraindicated? ☐ ineffective ☐ not tolerated ☐ contraindicated

Please indicate the length of the **first** medication trial: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

Please indicate the ***second*** medication that has been ineffective, not tolerated, or contraindicated:

☐ Enbrel (etanercept) ☐ Inflectra (infliximab-dyyb) ☐ Otezla (apremilast) ☐ Remicade (infliximab) ☐ Renflexis (infliximab-abda)
☐ Stelara (ustekinumab) ☐ Tremfya (guselkumab)

Was treatment ineffective, not tolerated, or contraindicated? ☐ ineffective ☐ not tolerated ☐ contraindicated

Please indicate the length of the **second** medication trial: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

Please indicate the ***third*** medication that has been ineffective, not tolerated, or contraindicated:

☐ Enbrel (etanercept) ☐ Inflectra (infliximab-dyyb) ☐ Otezla (apremilast) ☐ Remicade (infliximab) ☐ Renflexis (infliximab-abda)
☐ Stelara (ustekinumab) ☐ Tremfya (guselkumab)

Was treatment ineffective, not tolerated, or contraindicated? ☐ ineffective ☐ not tolerated ☐ contraindicated

Please indicate the length of the **third** medication trial: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

**Psoriatic Arthritis**

☐ Yes ☐ No Is there evidence that the disease is active?

☐ Yes ☐ No Does the patient have **axial** psoriatic arthritis?

→ ☐ Yes ☐ No Was the treatment with 2 or more non-steroidal anti-inflammatory drugs (NSAIDs) ineffective?

→ Please provide the names and length of treatment:

NSAID #1: _____

Please indicate length of treatment: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

NSAID #2: _____

Please indicate length of treatment: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

☐ Yes ☐ No Does the patient have **non-axial** psoriatic arthritis?

→ ☐ Yes ☐ No Does the patient have severe disease at presentation, defined as severe disability at onset with erosive disease involving multiple joints?

→ ☐ Yes ☐ No Was the treatment with methotrexate ineffective?

→ ☐ Yes ☐ No Was treatment with methotrexate not tolerated or contraindicated?

→ Please select: ☐ not tolerated ☐ contraindicated

☐ Yes ☐ No Was treatment with another conventional DMARD ineffective?

→ Please select: ☐ cyclophosphamide ☐ cyclosporine
☐ hydroxychloroquine ☐ leflunomide
☐ sulfasalazine ☐ Other: Please explain: _____

Please indicate length of treatment:
☐ Less than 1 month ☐ 1 month
☐ 2 months ☐ 3 months or greater

→ Indicate length of treatment: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

***Continued on next page***

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|---|---|---|---|
| | | | |

**G. CLINICAL INFORMATION (*continued*)** – Required clinical information must be completed in its entirety for all precertification requests.

How many of the following medications have been ineffective, not tolerated, or contraindicated: Enbrel (etanercept), Inflectra (infliximab-dyyb), Otezla (apremilast), Remicade (infliximab), Renflexis (infliximab-abda), Stelara (ustekinumab)?
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

Please indicate the ***first*** medication that has been ineffective, not tolerated, or contraindicated:
☐ Enbrel (etanercept) ☐ Inflectra (infliximab-dyyb) ☐ Otezla (apremilast) ☐ Remicade (infliximab) ☐ Renflexis (infliximab-abda)
☐ Simponi (golimumab) ☐ Stelara (ustekinumab)
Was treatment ineffective, not tolerated, or contraindicated? ☐ ineffective ☐ not tolerated ☐ contraindicated
Please indicate length of treatment: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

Please indicate the ***second*** medication that has been ineffective, not tolerated, or contraindicated:
☐ Enbrel (etanercept) ☐ Inflectra (infliximab-dyyb) ☐ Otezla (apremilast) ☐ Remicade (infliximab) ☐ Renflexis (infliximab-abda)
☐ Simponi (golimumab) ☐ Stelara (ustekinumab)
Was treatment ineffective, not tolerated, or contraindicated? ☐ ineffective ☐ not tolerated ☐ contraindicated
Please indicate length of treatment: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

Please indicate the ***third*** medication that has been ineffective, not tolerated, or contraindicated:
☐ Enbrel (etanercept) ☐ Inflectra (infliximab-dyyb) ☐ Otezla (apremilast) ☐ Remicade (infliximab) ☐ Renflexis (infliximab-abda)
☐ Simponi (golimumab) ☐ Stelara (ustekinumab)
Was treatment ineffective, not tolerated, or contraindicated? ☐ ineffective ☐ not tolerated ☐ contraindicated
Please indicate length of treatment: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

**Pyoderma Gangrenosum**

☐ Yes ☐ No Was treatment with first-line systemic glucocorticoids ineffective?
→ Please indicate the length of the glucocorticoids trial: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater
☐ Yes ☐ No Was treatment with first-line systemic cyclosporine ineffective?
Please indicate the length of the cyclosporine trial: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

**Rheumatoid Arthritis**

Please indicate the severity of the patient's rheumatoid arthritis: ☐ Mild ☐ Moderate ☐ Severe

☐ Yes ☐ No Is there evidence that the disease is active?

☐ Yes ☐ No Was treatment with methotrexate ineffective?
→ ☐ Yes ☐ No Was treatment with methotrexate not tolerated or contraindicated?
→ Please select: ☐ not tolerated ☐ contraindicated
☐ Yes ☐ No Was treatment with another conventional DMARD ineffective?
→ Please select: ☐ azathioprine ☐ cyclosporine ☐ hydroxychloroquine ☐ leflunomide ☐ sulfasalazine
Please indicate length of treatment: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater
→ Please indicate length of the methotrexate therapy: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

How many of the following medications have been ineffective, not tolerated, or contraindicated: Enbrel (etanercept), Inflectra (infliximab-dyyb), Remicade (infliximab), Renflexis (infliximab-abda), Simponi (golimumab), Simponi Aria (golimumab), Xeljanz/Xeljanz XR (tofacitinib)?
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

Please indicate the ***first*** medication that has been ineffective, not tolerated, or contraindicated:
☐ Enbrel (etanercept) ☐ Inflectra (infliximab-dyyb) ☐ Remicade (infliximab) ☐ Renflexis (infliximab-abda) ☐ Simponi (golimumab)
☐ Simponi Aria (golimumab) ☐ Xeljanz/Xeljanz XR (tofacitinib)
Was treatment ineffective, not tolerated, or contraindicated? ☐ ineffective ☐ not tolerated ☐ contraindicated
Please indicate the length of the first medication trial: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

Please indicate the ***second*** medication that has been ineffective, not tolerated, or contraindicated:
☐ Enbrel (etanercept) ☐ Inflectra (infliximab-dyyb) ☐ Remicade (infliximab) ☐ Renflexis (infliximab-abda) ☐ Simponi (golimumab)
☐ Simponi Aria (golimumab) ☐ Xeljanz/Xeljanz XR (tofacitinib)
Was treatment ineffective, not tolerated, or contraindicated? ☐ ineffective ☐ not tolerated ☐ contraindicated
Please indicate the length of the second medication trial: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

Please indicate the ***third*** medication that has been ineffective, not tolerated, or contraindicated:
☐ Enbrel (etanercept) ☐ Inflectra (infliximab-dyyb) ☐ Remicade (infliximab) ☐ Renflexis (infliximab-abda) ☐ Simponi (golimumab)
☐ Simponi Aria (golimumab) ☐ Xeljanz/Xeljanz XR (tofacitinib)
Was treatment ineffective, not tolerated, or contraindicated? ☐ ineffective ☐ not tolerated ☐ contraindicated
Please indicate the length of the third medication trial: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater

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**G. CLINICAL INFORMATION (*continued*)** – Required clinical information must be completed in its entirety for all precertification requests.

**Ulcerative Colitis**

☐ Yes ☐ No Is the patient hospitalized with active fulminant ulcerative colitis?
→ Please indicate the severity of the patient's ulcerative colitis: ☐ Mild ☐ Moderate ☐ Severe
☐ Yes ☐ No Is there evidence that the disease is active?
☐ Yes ☐ No Is the patient refractory to immunosuppression with corticosteroids (e.g., hydrocortisone, methylprednisolone, prednisone)?
→ ☐ Yes ☐ No Does the patient require continuous immunosuppression with corticosteroids (e.g., hydrocortisone, methylprednisolone, prednisone)?
→ Name and dose: Name: _____ Dose: _____
Please indicate the route: ☐ Oral ☐ IV
Length of time on therapy: ☐ Less than 10 days ☐ 10 to 29 days ☐ 30 days or greater
→ Name and dose: Name: _____ Dose: _____
Please indicate the route: ☐ Oral ☐ IV
Length of time on therapy: ☐ Less than 10 days ☐ 10 to 29 days ☐ 30 days or greater
☐ Yes ☐ No Was treatment with immunosuppressant agent (e.g., azathioprine, 6-mercaptopurine) ineffective?
→ ☐ Yes ☐ No Was treatment with immunosuppressant agent (e.g., azathioprine, 6-mercaptopurine) not tolerated or contraindicated?
→ ☐ not tolerated ☐ contraindicated
→ Provide the name of the drug(s): _____
→ Provide the name of the drug(s): _____
Please indicate length of treatment: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater
☐ Yes ☐ No Was treatment with 5-aminosalicylic acid agents (e.g., balsalazide, mesalamine, sulfasalazine) ineffective?
→ ☐ Yes ☐ No Was treatment with 5-aminosalicylic acid agents (e.g., balsalazide, mesalamine, sulfasalazine) not tolerated or contraindicated?
→ ☐ not tolerated ☐ contraindicated
→ Provide the name of the drug(s): _____
→ Provide the name of the drug(s): _____
Please indicate length of treatment: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater
→ Please select the symptoms the patient exhibit: ☐ more than 10 stools per day ☐ continuous bleeding ☐ abdominal pain ☐ distension ☐ acute, severe toxic symptoms, including fever and anorexia

☐ Yes ☐ No Has treatment with any of the following have been ineffective, not tolerated, or contraindicated: Entyvio (vedolizumab), Inflectra (infliximab-dyyb), Remicade (infliximab), Simponi (golimumab) or Xeljanz (tofacitinib)?
Check all that apply: ☐ Entyvio (vedolizumab) ☐ Inflectra (infliximab-dyyb) ☐ Remicade (infliximab) ☐ Simponi (golimumab) ☐ Xeljanz (tofacitinib)
Please indicate the length of the medication trial: ☐ Less than 1 month ☐ 1 month ☐ 2 months ☐ 3 months or greater
Was treatment ineffective, not tolerated, or contraindicated? ☐ ineffective ☐ not tolerated ☐ contraindicated

**For Continuation of Therapy (clinical documentation required for all requests):**

Please indicate the length of time on Humira (adalimumab): _____
☐ Yes ☐ No Is this continuation request a result of the patient receiving samples of Humira (adalimumab)? (Sampling of Humira (adalimumab) does not guarantee coverage under the provisions of the pharmacy benefit.)
☐ Yes ☐ No Will Humira (adalimumab) be used concomitantly with apremilast, tofacitinib, or other biologic DMARDs (e.g., etanercept, infliximab)?
☐ Yes ☐ No Is there clinical documentation supporting disease stability?
☐ Yes ☐ No Is there clinical documentation supporting disease improvement?
☐ Yes ☐ No Does the patient have any risk factors for TB?
→ ☐ Yes ☐ No Has the patient had a TB test within the past year?
→ (check all that apply): ☐ PPD test ☐ interferon-gamma assay (IGRA) ☐ chest x-ray
Please enter the results of the TB test: ☐ Positive ☐ Negative ☐ Unknown

**For Crohn's disease, Juvenile idiopathic arthritis (juvenile rheumatoid arthritis), Plaque psoriasis, Rheumatoid arthritis, Ulcerative colitis only:**
Please indicate the severity of the patient's disease at baseline (pretreatment with Humira (adalimumab)): ☐ Mild ☐ Moderate ☐ Severe

**H. ACKNOWLEDGEMENT**

**Request Completed By *(Signature Required):*** _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.