

Health New England
Medication Request Form (MRF)/Prescription Request
Humira® (adalimumab)

Prior Authorization

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|--------------------------------------------------------|
| DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY |
| Contacted: |
| Physician: |
| Pharmacy: |
| Patient: |
| |
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|--------------------------------------------------------|
| DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY |
| Approved: |
| Quantity approved: |
| PA from and thru date: |
| PA # |
| Denied: |
| Returned: |

Instructions:

This form is to be used by participating physicians and pharmacy providers to obtain coverage of Humira®. Please complete this form and fax to ICORE Healthcare at (866) 364-2673. If you have any questions regarding this process, please contact ICORE Healthcare at (800) 775-5138.

J-Codes: Humira® J0135, unit = 20mg (if administered in physicians office only)

Medication Request Information (please complete each section of this form prior to transmittal):

| Patient Information | Physician Information |
|-------------------------------------------------|---------------------------------------------|
| Patient Name (required): | Physician Name (required): |
| Patient Cell Phone #: () - | Specialty (required): |
| Patient HNE ID# (required): | NPI #: |
| Patient Date of Birth (required): | HNE Provider #: |
| Allergies: | DEA # (required): |
| Diagnosis (required): | Telephone #: () - |
| | Fax # (required): () - |

Drug Information

Preferred Drug/Strength/Form: Humira Pre-filled Syringe Pen

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|------------------------------------------------------------------------|------------------------------|-----------------|
| Dose, Directions, and length of treatment (please be specific): | Quantity (per month): | Refills: |
|------------------------------------------------------------------------|------------------------------|-----------------|

| | |
|-----------------------------|--------------|
| Physician Signature: | Date: |
|-----------------------------|--------------|

Indication:

Moderate to Severe Rheumatoid Arthritis.

Psoriatic Arthritis

Diagnosis of Ankylosing Spondylitis

Crohn's Disease

Juvenile Idiopathic Arthritis

Plaque Psoriasis (moderate to severe)

Other (please describe): _____

Documentation of Medical Necessity (check all that apply):

Patient has been seen by a Rheumatologist within the previous 12 months.

Request is for continuation of therapy

Patient is intolerant to or failed therapy of at least one (1) DMARD or immunomodulator (including methotrexate, sulfasalazine, hydroxychloroquine, aurothioglucose, auranofin, gold sodium thiomalate, azathioprine, d-penicillamine, cyclosporine, infliximab, etanercept, leflunomide, or anakinra).

Patient is steroid dependent (for Crohn's Disease)

Active infections have been excluded (required). (including but not limited to chronic or localized infections, histoplasmosis, cytomegalovirus, tuberculosis, HIV)

Pregnancy has been excluded or if female is of child-bearing age appropriate contraception is being utilized (use with caution)

The patient will not receive another tumor necrosis factor medications (TNF) such as Enbrel (etanercept), Kineret (anakinra), Remicade (infliximab), Arava (leflunomide), or Cimzia (certolizumab pegol)

Other pertinent history: _____