CHORUS COMMUNITY HEALTH PLANS

Prior Authorization Form: **Humira**

If this is an urgent request, please call Chorus Community Health Plans Pharmacy Services.
Otherwise, please return completed form – Phone: 844-201-4677 or Fax: 844-201-4675

Please type or print neatly. Please complete all sections of this form. Incomplete responses may delay this request.

Office Contact:		Provider Specialty:		
Provider First Name:		Provider Last Name:		
Provider Phone:		Provider Fax:		Provider NPI #:
Patient Name:		CCHP Member ID Number:		Patient DOB:
Drug Requested:	Strength:	Frequency:	Qty Dispensed:	Patient Age:

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

New medication **Ongoing medication**	If ongoing, provide date started:	If medication is ongoing, Did the member show improvement while on therapy?	**Yes** **No**

Diagnosis:	Date of diagnosis:

Please indicate place of administration / infusion?	**Physician's Office** **Hospital/Facility** **Patient Home**	Please indicate how medication will be billed: **Billed directly by the provider via JCODE** **Provide JCODE:______________________** **Billed by a pharmacy and delivered to the provider** **Billed by a pharmacy and delivered to the patient**
Please provide facility/provider name and address:		

Please complete the following questions for *all* diagnoses.

Please indicate disease severity:	**Mild**	**Moderate**	**Severe**
Is there evidence of Infection?	**Yes**	**No**	

Date of PPD (tuberculin) test:	Result of PPD test: **Positive** **Negative**

Is the member currently using another TNF-blocking agent or biologic agent in combination with Humira? **Yes** **No**
If yes, please indicate drug name:

Please indicate the diagnosis on the left and complete the corresponding questions.

Diagnosis	Questions	
Rheumatoid Arthritis **Juvenile Idiopathic Arthritis**	Has the member tried and failed Methotrexate for at least 3 months?	**Yes** **No**
	Please provide dates of therapy and dose:	
	Reason for discontinuation:	
	Please indicate if the member tried and failed any of the following for at least 3 months? **Leflunomide (Arava)** **Minocycline** **Sulfasalazine (Azulfidine)** **Hydroxychloroquine (Plaquenil)**	
	Please provide dates of therapy and dose:	
	Reason for discontinuation:	
Psoriatic Arthritis	Does the member have dominant **peripheral** disease?	**Yes** **No**
	Does the member have dominant **axial** disease?	**Yes** **No**
	Please indicate if the member tried and failed any of the following for at least 3 months? **Methotrexate** **Cyclosporine (Neoral, Sandimmune)**	

	Sulfasalazine (Azulfidine) **Leflunomide(Arava)**	
	Please provide dates of therapy and dose:	
	Reason for discontinuation:	
	Has the member tried and failed any NSAIDs for at least 3 months? If yes, please indicate drug name(s):	**Yes** **No**
	Please provide dates of therapy and dose:	
	Reason for discontinuation:	

Ankylosing Spondylitis	Does the member have dominant **peripheral** disease?	**Yes** **No**
	Does the member have dominant **axial** disease?	**Yes** **No**
	Please indicate if the member tried and failed any of the following for at least 3 months? **Methotrexate** **Sulfasalazine (Azulfidine)**	
	Please provide dates of therapy and dose:	
	Reason for discontinuation:	
	Has the member tried and failed any NSAIDs for at least 3 months?	**Yes** **No**
	Please indicate drug name(s) and dose:	
	Please provide dates of therapy:	
	Reason for discontinuation:	
Plaque Psoriasis	Please indicate body surface area (BSA) involvement: **Less than 10%** **Greater than or equal to 10%**	
	Does the member have psoriasis on the palms, soles, head, neck, or genitalia?	**Yes** **No**
	Has the member tried and failed topical treatments?	**Yes** **No**
	If yes, indicate drug name :	
	Reason for discontinuation:	
	Has the member tried and failed phototherapy or photochemotherapy	**Yes** **No**
	Please indicate if the member tried and failed any of the following for at least 3 months? **Methotrexate** **Cyclosporine (Neoral, Sandimmune)** **Acitretin (Soriatane)**	
	Please provide dates of therapy and dose:	
	Reason for discontinuation:	
Crohn's Disease	Has the member tried and failed corticosteroids?	**Yes** **No**
	Please provide dates of therapy and dose:	
	Reason for discontinuation:	
	Please indicate if the member tried and failed any of the following for at least 3 months? **Azathioprine (Imuran)** **6-mercaptopurine (Purinethol)** **Other, Please list drug name:**	
	Please provide dates of therapy and dose:	
	Reason for discontinuation:	
Ulcerative Colitis	Has the member tried and failed corticosteroids?	**Yes** **No**
	If yes, please provide dates of therapy and dose:	

	Reason for discontinuation:		
	Please indicate if the member tried and failed any of the following for at least 3 months?		
	Sulfasalazine (Azulfidine)	**Mesalamine (Asacol)**	**Azathioprine (Imuran)**
	6-mercaptopurine (Purinethol)	**Other, Please list drug name:**	
	Please provide dates of therapy and dose:		
	Reason for discontinuation:		

Please provide any additional information which should be considered in the space below: