

## Sterling Retiree Rx Prior Authorization Form

### HUMIRA (Adalimumab)

**Coverage Criteria / Required Medical Information**

**Prescriber must be Rheumatologist, Dermatologist or Gastroenterologist, as appropriate.**

**Moderate to Severe Psoriatic Arthritis** with predominantly peripheral symptoms **or Moderate to Severe RA or JIA:** patient has had at least an 8-week maximum tolerated dose trial and failure or has an intolerance or contraindication to at least 1 nonbiologic DMARD (e.g., methotrexate, cyclosporine, azathioprine, sulfasalazine, leflunomide, hydroxychloroquine).

**Psoriatic Arthritis** with predominantly axial symptoms **or Ankylosing Spondylitis:** patient has tried and failed to respond to 2 NSAIDs unless patient has a contraindication or intolerance to NSAIDs.

**Moderate to Severe Plaque Psoriasis:** affected area is greater than 10% of BSA **or** an area that will affect crucial daily functions (e.g., feet, hands) **and** patient has tried and failed or has an intolerance or contraindication to at least a 60-day trial of 2 conventional therapies including high potency topical steroid therapy, calcipotriene, phototherapy, retinoids, methotrexate, or cyclosporine **and** patient must be at least 18 years of age.

**Crohn's Disease:** patient has tried and failed or has a contraindication or intolerance to at least a 60-day trial of 2 of the following conventional therapies: sulfasalazine, balsalazide, mesalamine, azathioprine, cyclosporine, methotrexate, mercaptopurine, corticosteroids **or** patient has had an inadequate response or intolerance to either Remicade or Cimzia.

Patient must be screened for latent TB and assessed for Hep B risk and, if appropriate, be treated.

**Continuation of Therapy:** patient must show an improvement in clinical symptoms or delay in progression of disease.

**Exclusion Criteria**

Active infection (including TB, sepsis); concurrent use with other biologics

### Patient Information

<b>Name</b>					
<b>Enrollment/Card-holder ID Number</b>					
<b>Group/Plan</b>		<b>Male</b>		<b>Female</b>	
<b>Date of Birth</b>		<b>Age</b>		<b>Weight in Kg</b>	
<b>Street Address</b>					
<b>City</b>		<b>State</b>		<b>Zip</b>	

### Physicians Information

<b>Name</b>					
<b>Agent</b>		<b>Contact Name</b>			
<b>Specialty/Office</b>					
<b>Clinic Name</b>					
<b>Street Address</b>					
<b>City</b>		<b>State</b>		<b>Zip</b>	
<b>Phone</b>		<b>Fax</b>			



**Sterling Retiree Rx Prior Authorization Form**

Requested Drug	
HUMIRA	Reason for Request
Condition/Diagnosis Related	
Clinical Drug/Lab History Pertinent to Request	
Labs: Baseline/Ongoing	Strength/Dosage
Please List Alternative Formulary Drugs	
Comments	

Physicians Signature: \_\_\_\_\_ Fax Form to 1-877-481-3704