

UPMC HEALTH PLAN

Humira

Prior Authorization Form

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services.
Otherwise please return completed form to:

UPMC HEALTH PLAN PHARMACY SERVICES

PHONE 800-979-UPMC (8762)

FAX 412-454-7722

PLEASE TYPE OR PRINT NEATLY

Please complete all sections of this form AND include details of past relevant medical treatment, which substantiates the need for an exception to using formulary alternatives, i.e. past prescription treatment failures, documented side effects, chart documentation, lab values, etc. Incomplete responses may delay this request.

Office Contact:		Provider Specialty:	
Provider First Name:		Provider Last Name:	
Provider Phone:		Provider Fax:	
Patient Name:		Patient UPMC Health Plan ID Number:	Patient DOB:
Strength:	Frequency:	Qty Dispensed:	Patient Age:
<input type="checkbox"/> New medication	If ongoing, provide date started:	If medication is ongoing, Did the member show improvement while on therapy?	<input type="checkbox"/> Yes
<input type="checkbox"/> Ongoing medication			<input type="checkbox"/> No
Diagnosis:		Date of diagnosis:	

Medical History

Please indicate disease severity:		<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Please indicate number of joints affected: _____ (For diagnosis of Psoriatic Arthritis only)				
Date of PPD (tuberculosis) Test: _____			Result of PPD: _____	
Is the member currently using another TNF-blocking agent or biologic agent in combination with Humira?				<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>The following questions are for the diagnosis of Ankylosing Spondylitis only:</i>				
Does the member have Peripheral Arthritis?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the member have axial disease?	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<i>The following questions are for the diagnosis of Plaque Psoriasis only:</i>				
Please indicate % of BSA affected		<input type="checkbox"/> Less than 10 % <input type="checkbox"/> Greater than 10%		
Does the member have plaque psoriasis on the palms, soles, head, neck, or genitalia?				<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the member tried and failed topical treatments? If yes, please specify drug names below				<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the member tried phototherapy (UVB) or photochemotherapy (psoralens with UVA)?				<input type="checkbox"/> Yes <input type="checkbox"/> No

Please complete for all diagnosis. Choose from the list below previous medication trials.

Drug Name	Strength/ Frequency	Dates of Therapy	Reason for Discontinuing
<input type="checkbox"/> Methotrexate			
<input type="checkbox"/> NSAIDs, Please List:			
<input type="checkbox"/> Sulfasalazine			
<input type="checkbox"/> Mesalamine			
<input type="checkbox"/> Corticosteroids			
<input type="checkbox"/> Azathioprine			
<input type="checkbox"/> Mercaptopurine			
<input type="checkbox"/> Soriatane			
<input type="checkbox"/> Cyclosporine			
<input type="checkbox"/> Other, Please List:			