PRIOR AUTHORIZATION FORM
Humira - Medicare

Unless otherwise indicated below, authorization quantities are limited to the manufacturer recommended dosage

selecthealth

P.O. Box 30192
Salt Lake City, UT 84130-0192

SELECTHEALTH.ORG

Complete online at www.selecthealth.org/pa or fax back to: 801-650-3170

For questions or clarifications, call: 801-442-9988 or 855-442-9988

Patient Information	
Patient's Name:	Patient's Date of Birth:
Patient's ID:	Patient's Phone #:
Diagnosis Code(s):	
Requesting Provider Information	
Name:	Phone #:
NPI/DEA:	Fax #:
Address:	Supervising Physician (if requesting provider bills under a different provider)
	Name:
	NPI/DEA:
Servicing Provider Information (if different than requesting provider)	
Name of provider or facility:	Phone number:
NPI/DEA:	Address:

Drug Name and Strength:	Directions / SIG:
☐ Urgent Request (24 hours)	☐ Standard Request (72 hours)

Q1. What is the maintenance dosing requested?

- ☐ 40 mg or less every other week
- ☐ 20 mg to 40 mg once weekly OR 80 mg every other week
- ☐ Other

Q2. If other, please specify:

Q3. What is the patient's diagnosis?

- ☐ Ankylosing Spondylitis (AS)
- ☐ Crohn's Disease (CD)
- ☐ Hidradenitis Suppurativa (HS)
- ☐ Psoriatic Arthritis (PsA)
- ☐ Rheumatoid Arthritis (RA)
- ☐ Ulcerative Colitis (UC)- Adult Onset

☐ Juvenile Idiopathic Arthritis (JIA)
☐ Juvenile Idiopathic Arthritis with Uveitis
☐ Plaque Psoriasis (PsO)
☐ Ulcerative Colitis (UC)- Pediatric Onset
☐ Uveitis (UV)
☐ Other

Q4. If other, please specify:

Q5. For RA, PsA and JIA, has the patient failed at least three months of therapy on at least ONE of the following?

☐ Methotrexate
☐ Leflunomide
☐ Hydroxychloroquine
☐ Sulfasalazine
☐ Injectable gold salts
☐ Oral gold
☐ Azathioprine
☐ D-penicillamine
☐ Cyclosporine
☐ None of the above

Q6. For hidradenitis suppurativa, has the patient failed therapy or had an inadequate response to a treatment of oral antibiotics?

☐ Yes ☐ No

Q7. For hidradenitis suppurativa, does the patient have lesions present in at least two distinct anatomical areas, one of which is Hurley Stage II or III?

☐ Yes ☐ No

Q8. For noninfectious uveitis, has the patient failed previous treatment with corticosteroids?

☐ Yes ☐ No

Q9. For UC (adult onset) or Crohn's disease weekly or 10-day dosing, does the provider attest that the patient is not in remission or losing response with every 14-day dosing?

☐ Yes ☐ No

Q10. If yes, chart notes including documentation of fecal calprotectin level, colonoscopy or MRI are required for the request of this medication. Failure to provide chart notes will result in a delay in decision and/or denial. Did you attach relevant chart notes?

☐ Yes ☐ No

Q11. Please provide lab values with reference range for trough drug levels and antibodies:

Q12. For increased dosing for RA to 40mg weekly or every 10 days, or 80 mg every other week, has the patient tried every other week dosing with insufficient response?

☐ Yes ☐ No

Q13. For plaque psoriasis, has the patient failed therapy with ONE of the following: methotrexate, cyclosporine or acitretin therapy?

☐ Yes ☐ No

Q14. Does the patient’s treatment plan contain combination therapy with another biologic medication, JAK inhibitor or Otezla?

☐ Yes	☐ No
Q15. Additional Comments:	

This form is intended for SelectHealth members only. All requests for preauthorization should be sent via fax to 1-801-442-0413. Missing, inaccurate, or incomplete information may cause a delay or denial of authorization.

_____ _____

Prescriber Signature Date