

NOTE: Failure to respond within 36 business hours will result in a denial for lack of information

Humira (adalimumab)

Prior Authorization Request (Physician to Complete)



Visit www.wellmark.com for the Wellmark Drug List for current medication tier levels and updated PA Forms

Facsimile Transmittal Sheet

Date: ____/____/____

To: Wellmark Pharmacy Services

From (Prescriber's Name): _____

Fax Number: (866) 884-4345

Prescriber's DEA Number: _____

Phone Number: (800) 600-8065

Prescriber's Phone Number: _____

Prescriber's Specialty: _____

Prescriber's Fax Number: _____

Prescriber's Office Address: _____

Street

Suite #

City

State

Zip

Patient Name: _____

Patient ID: _____ Patient DOB: ____/____/____

Please answer the following questions and fax this form back to (866) 884-4345. All fields are REQUIRED.

1. Does the patient have one of the following diagnoses? **Please complete all corresponding questions**

Ankylosing spondylitis

Polyarticular course, juvenile idiopathic arthritis: patient's weight: ____ kg

Adult, chronic severe plaque psoriasis: duration > 6 months? Yes No

Does the patient have moderate to severe psoriasis affecting at least 10% of the patient's body surface area (BSA) or psoriasis affecting the hands, feet, face, or genitals? Yes No

Active psoriatic arthritis: Does the patient have at least 3 swollen/tender joints? Yes No

Does the patient have plaque psoriasis with a target lesion \geq 2cm in diameter? Yes No

Adult rheumatoid arthritis, moderately to severely active

Crohn's Disease

2. Prescriber's specialty: _____

3. Has the patient been evaluated for active and latent tuberculosis? Yes No

4. Has the patient shown inadequate response to any of the following topical? Yes No (*check all that apply*)

anthralin coal tar glucocorticoids calcipotriene (Dovonex) tazarotene (Tazorac)

contraindication: _____

5. Has the patient shown inadequate response any of the following systemic therapies? Yes No (*check all that apply*)

glucocorticoids methotrexate leflunomide non-steroidal anti-inflammatory drugs (NSAID's)

acitretin (Soriatane) gold cyclosporine UVB/PUVA phototherapy

d-penicillamine azathioprine sulfasalazine hydroxychloroquine

contraindication: _____

6. Does the patient have any of the poor prognostic factors for rheumatoid arthritis listed below? Yes No

Functional limitation Felty's syndrome rheumatoid nodules Rheumatoid Factor positive (RF+)

RA Lung disease RA Vasculitis Positive anti-cyclic citrullinated peptide antibodies (anti-CCP)

Extraarticular disease Secondary Sjogren's syndrome Bony erosions by radiography

7. Dose per injection: _____ mg

Frequency of injection: _____ per _____

Attach lab results and other documentation as necessary

Printed Name

Signature

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient, you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received this fax in error, please immediately notify the sender by telephone and destroy this original fax message.