



Date of Request: \_\_\_\_\_

### Sterling Retiree Rx Prior Authorization Form

#### HUMIRA (Adalimumab)

##### Coverage Criteria / Required Medical Information

**Rheumatoid Arthritis/Juvenile Rheumatoid Arthritis/ Psoriatic Arthritis** - patient must demonstrate inadequate response to at least 1 DMARD or intolerance to 2 DMARDs.

**Plaque Psoriasis** - patient must be a candidate for systemic therapy or phototherapy.

**Ankylosing Spondylitis** - patient must demonstrate inadequate response or intolerance to at least 2 NSAIDs. If the ankylosing spondylitis is predominantly peripheral arthritis, patient must demonstrate an inadequate response or intolerance to sulfasalazine only.

**Crohn's Disease** - patient must demonstrate an inadequate response to 2 conventional therapy or Remicade.

##### Exclusion Criteria

Patient must be evaluated for latent TB with a PPD test and be treated if positive. Patients are excluded if they have an active infection or are on a concurrent biologic response modifier. Patient must also be assessed for the risk of hepatitis B and, if appropriate, be tested.

<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>			

#### Requested Drug

<b>HUMIRA</b>	<b>Reason for Request</b>
<b>Condition/Diagnosis Related</b>	

#### Clinical Drug/Lab History Pertinent to Request

<b>Labs: Baseline/Ongoing</b>	<b>Strength/Dosage</b>
<b>Please List Alternative Formulary Drugs</b>	

<b>Comments</b>	
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Physicians Signature: \_\_\_\_\_

Fax Form to 1-877-847-9904