

Blue Cross Blue Shield of Vermont and The Vermont Health Plan Prior Approval Form

Humira® (Adalimumab)

BCBSVT and TVHP Fax # (888)–255-1006

If approval criteria are met, BCBSVT/TVHP will authorize coverage of Humira® (adalimumab). Thank you for your assistance.

PLEASE COMPLETE THE FOLLOWING SECTIONS:

Date of Request _____ Patient Name: _____
 Member ID#: _____ Date of Birth: _____
 Provider Name: _____ Provider Phone: _____
 Provider Fax: _____ PCP Name: _____

INDICATIONS FOR USE

	YES	NO
1. Is patient diagnosed with moderately to severely active rheumatoid arthritis? OR Is patient diagnosed with psoriatic arthritis? OR Is patient diagnosed with Ankylosing Spondylitis? OR Is patient diagnosed with Crohn's Disease? OR Is patient diagnosed with moderate to severe chronic plaque psoriasis	<input type="checkbox"/>	<input type="checkbox"/>
2. Has patient demonstrated a negative tuberculin skin test?	<input type="checkbox"/>	<input type="checkbox"/>
3. Is patient ≥ 18 years of age?	<input type="checkbox"/>	<input type="checkbox"/>
4. Has patient previously received a (DMARD) disease-modifying antirheumatic agent?	<input type="checkbox"/>	<input type="checkbox"/>
5. Has patient previously received methotrexate?	<input type="checkbox"/>	<input type="checkbox"/>
6. If this is a renewal please indicate the following: Patient has received 4 months of therapy and has demonstrated improvement to therapy based on American College of Rheumatology (ACR) criteria? Improvement in joint counts and 3 out of 5 of the following: physician assessment, patient assessment, ESR, pain scale, and functional questionnaire. Patient has shown improvement and has been on therapy for ≥ 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
7. If patient has Psoriasis, What is the Body Surface area of the plaques?		
8. If being used for treatment of psoriasis, Does area involve face, hand, feet, or genitalia?	<input type="checkbox"/>	<input type="checkbox"/>
9. If patient has Psoriasis, has patient had a trial of methotrexate?	<input type="checkbox"/>	<input type="checkbox"/>
10. Does Patient has a known hypersensitivity to any component of adalimumab.	<input type="checkbox"/>	<input type="checkbox"/>
11. Does Patient has an active chronic or localized infection.	<input type="checkbox"/>	<input type="checkbox"/>
12. Does Patient have a latent infection or positive tuberculin test	<input type="checkbox"/>	<input type="checkbox"/>
13. Is Patient receiving Anakinra.	<input type="checkbox"/>	<input type="checkbox"/>
Prescription be dispensed at (circle one): Provider Office RESTAT Pharmacy		

Initial approval will be for a 4-month period. If patient has demonstrated a response to therapy, an additional 8 months will be authorized. Dispensed in ONLY 30 days supplies

Dose: _____ Frequency: _____ Duration of Therapy: _____

PRESCRIBER SIGNATURE _____ DATE _____

By signing above, the prescriber confirms all information provided is accurate and verifiable via member records.