



ADALIMUMAB (HUMIRA®)
PRIOR REVIEW/CERTIFICATION FAXBACK FORM
INCOMPLETE FORMS MAY DELAY PROCESSING

ALL NC PROVIDERS MUST PROVIDE THEIR 5 DIGIT BCBSNC PROVIDER ID# BELOW

PRESCRIBER INFORMATION		PATIENT INFORMATION
PHYSICIAN NAME	PROVIDER ID/TAX ID (if out of state must have tax ID)	PATIENT NAME
CONTACT PERSON/PRACTICE NAME		PATIENT'S BCBSNC ID
PRACTICE PHONE	PRACTICE FAX	PATIENT'S DATE OF BIRTH
PRACTICE ADDRESS	CITY	STATE ZIP

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Dx Code: _____

- A. Will the patient be receiving treatment with more than one biologic agent at the same time?
 (e.g., Enbrel, Kineret, Cimzia, Simponi, Remicade, Orencia or Rituxan)..... Yes No
- B. Has the patient been screened for the presence of latent TB?..... Yes No

C. Please check the appropriate diagnosis and answer the related questions:

Rheumatoid Arthritis, Psoriatic Arthritis, or Juvenile Idiopathic Arthritis

1. Has the patient experienced a therapeutic failure/inadequate response with Methotrexate (MTX) or has a contraindication?..... Yes No
- OR** 2. Is the patient being treated for newly diagnosed rheumatoid arthritis or for rapidly progressive and advancing disease? Yes No

Plaque Psoriasis

1. Is the patient being managed by a dermatologist?..... Yes No
2. Does the patient have Body Surface Area (BSA) involvement of at least 5% or involvement of the palms, soles, head and neck, or genitalia, causing disruption in normal daily activities or employment?..... Yes No
3. Has the patient tried and failed systemic therapy (e.g., Methotrexate, Cyclosporine, Acitretin [Soritane]) or has a contraindication to these therapies?..... Yes No
- If yes, list agents and/or contraindications: _____

Crohn's Disease

1. Does the patient have moderately to severely active Crohn's disease?..... Yes No
2. Has the patient had inadequate response to conventional therapy?..... Yes No
- List therapies: _____

Ankylosing Spondylitis

*****PLEASE NOTE: If you are prescribing greater than 80 mg of Humira every 28 days, please complete and sign Page 2**

Please certify the following by signing and dating below:

I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that BCBSNC may request medical records for this patient at any time in order to verify this information. I further understand that if BCBSNC determines this information is not reflected in my patient's medical records, BCBSNC may request a refund of any payments made and/or pursue any other remedies available.

Prescriber's Signature (Required): _____ Date: _____

Fax completed form to BCBSNC at 1-800-795-9403

Last Revision Date: 10/1/11



**COMPLETE PAGE 2 ONLY IF REQUESTING A QUANTITY LIMIT
EXCEPTION FOR HUMIRA**

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PRACTICE ADDRESS	CITY	STATE ZIP

If you are requesting a quantity above the amount listed, check the appropriate box and provide the medical necessity of the increased dosage requested.

*Please note: This medication requires a **prior authorization** before a quantity limit override can be considered. Before submitting a request for a quantity level override, please ensure that a prior approval authorization has been submitted and/or approved (page 1). Otherwise, this request will deny.*

Dx Code: _____

Requested drug dose:

greater than 80 mg of Humira every **28 days**

Provide dosage requested and a description of medical necessity / rationale for this request:

Please certify the following by signing and dating below:

I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that BCBSNC may request medical records for this patient at any time in order to verify this information. I further understand that if BCBSNC determines this information is not reflected in my patient's medical records, BCBSNC may request a refund of any payments made and/or pursue any other remedies available.

Prescriber's Signature (Required): _____ Date: _____

Fax completed form to BCBSNC at 1-800-795-9403