

# HUMIRA® DISEASE MODIFYING ANTIRHEUMATIC DRUG PRIOR REVIEW FAXBACK FORM

PRESCRIBER INFORMATION		PATIENT INFORMATION	
PRESCRIBER NAME	PROVIDER ID/TAX ID <small>(if out of state must have Tax ID)</small>	PATIENT NAME	
CONTACT PERSON		BCBSNC ID	
PRESCRIBER PHONE	PRESCRIBER FAX	DATE OF BIRTH	
PRESCRIBER ADDRESS	CITY	STATE	ZIP

- Rheumatoid Arthritis, Psoriatic Arthritis, Juvenile Idiopathic Arthritis or Ankylosing Spondylitis**
1. Has the patient been screened for the presence of latent TB infection? .....  Yes  No
  2. Has the patient experienced a therapeutic failure/inadequate response with Methotrexate (MTX) or has a contraindication? .....  Yes  No
- OR**
3. Is the patient being treated for newly diagnosed rheumatoid arthritis or for rapidly progressive and advancing disease? .....  Yes  No
- OR**
4. Does the patient have active ankylosing spondylitis? .....  Yes  No

- Plaque Psoriasis**
1. Has the patient been screened for the presence of latent TB infections?.....  Yes  No
  2. Is the patient being managed by a dermatologist? .....  Yes  No
  3. 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
  4. 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. Has the patient been screened for the presence of latent TB infection? .....  Yes  No
  2. Does the patient have moderately to severely active Crohn's disease? .....  Yes  No
  3. Has the patient had inadequate response to conventional therapy? .....  Yes  No
- List therapies tried: \_\_\_\_\_

**Other Pertinent Information:** \_\_\_\_\_

I certify that the above information is accurate and **is documented in the medical record.**

Prescriber's Signature Required: \_\_\_\_\_ Date \_\_\_\_\_

**Fax completed form to 1-800-795-9403**

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