Prescriber Criteria Form Adalimumab 2024 PA Fax 107-A v3 010124.docx Humira (adalimumab), Amjevita (adalimumab-atto), Idacio (adalimumab-aacf), Adalimumab-Aacf Coverage Determination
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Adalimumab.

Drug Name (select from list of drugs shown):

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Has the patient previously received the requested drug for one of the following conditions: A) rheumatoid arthritis, B) polyarticular juvenile idiopathic arthritis, C) psoriatic arthritis, D) ankylosing spondylitis, E) non-radiographic axial spondyloarthritis, F) Crohn's disease, G) ulcerative colitis, H) plaque psoriasis, I) hidradenitis suppurativa, J) non-infectious intermediate, posterior or panuveitis, K) Behcet's syndrome? [If yes, then no further questions.]	Yes	No
2	Does the patient have a diagnosis of moderately to severely active rheumatoid arthritis (RA)? [If no, then skip to question 4.]	Yes	No
3	Does the patient meet either of the following criteria: A) Patient has experienced an inadequate treatment response, intolerance, or has a contraindication to methotrexate (MTX), B) Patient has experienced an inadequate treatment response or intolerance to a prior biologic disease-modifying antirheumatic drug (DMARD) or a targeted synthetic DMARD? [No further questions.]	Yes	No
4	Does the patient have a diagnosis of moderately to severely active polyarticular juvenile idiopathic arthritis? [If yes, then no further questions.]	Yes	No

5	Does the patient have a diagnosis of active psoriatic arthritis? [If yes, then no further questions.]	Yes	No
6	Does the patient have a diagnosis of active ankylosing spondylitis or non-radiographic axial spondyloarthritis? [If no, then skip to question 8.]	Yes	No
7	Has the patient experienced an inadequate treatment response or intolerance to a non-steroidal anti-inflammatory drug (NSAID) OR does the patient have a contraindication that would prohibit a trial of NSAIDs? [No further questions.]	Yes	No
8	Does the patient have a diagnosis of moderate to severe plaque psoriasis? [If no, then skip to question 11.]	Yes	No
9	Does the patient meet one of the following criteria: A) at least 3 percent of body surface area (BSA) is affected by plaque psoriasis at the time of diagnosis, B) crucial body areas (e.g., feet, hands, face, neck, groin, intertriginous areas) are affected by plaque psoriasis at the time of diagnosis? [If no, then no further questions.]	Yes	No
10	Does the patient meet any of the following criteria: A) patient has experienced an inadequate treatment response or intolerance to either phototherapy (e.g., ultraviolet B [UVB], psoralen plus ultraviolet A [PUVA]) or pharmacologic treatment with methotrexate, cyclosporine, or acitretin, B) pharmacologic treatment with methotrexate, cyclosporine, or acitretin is contraindicated, C) patient has severe psoriasis that warrants a biologic as first-line therapy (i.e., at least 10 percent of the body surface area [BSA] or crucial body areas [e.g., hands, feet, face, neck, scalp, genitals/groin, intertriginous areas] are affected)? [No further questions.]	Yes	No
11	Does the patient have a diagnosis of moderately to severely active Crohn’s disease? [If no, then skip to question 13.]	Yes	No
12	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to at least one conventional therapy (e.g., corticosteroids)? [No further questions.]	Yes	No
13	Does the patient have a diagnosis of moderately to severely active ulcerative colitis? [If no, then skip to question 15.]	Yes	No
14	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to at least one conventional therapy (e.g., corticosteroids)? [No further questions.]	Yes	No
15	Does the patient have a diagnosis of moderate to severe hidradenitis suppurativa? [If yes, then no further questions.]	Yes	No

16	Does the patient have a diagnosis of non-infectious intermediate, posterior or panuveitis? [If no, then skip to question 18.]	Yes	No
17	Has the patient experienced an inadequate treatment response or intolerance to a corticosteroid OR does the patient have a contraindication that would prohibit a trial of corticosteroids? [No further questions.]	Yes	No
18	Does the patient have a diagnosis of Behcet's syndrome?	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____