



HUMIRA® (adalimumab) - Prior Authorization/Prescription/Patient Enrollment Form

Complete form in its entirety and fax to number listed below

PATIENT INFORMATION

Last Name		First Name		Middle Initial
Date of Birth	Sex M <input type="checkbox"/> F <input type="checkbox"/>	Medicaid ID #		
Allergies: <input type="checkbox"/> NKA or _____				
Street Address		City		
State	County	Zip Code		
Home Phone		Cell Phone		
Parent/Guardian		Day Telephone	Night Telephone	
Emergency Contact		Relationship	Telephone	

PRESCRIBER INFORMATION

Prescriber's Name	NPI Number	DEA Number
Telephone Number	Fax Number	Hospital/Clinic Name
Street Address		City
State	County	Zip Code
Contact Person at Office		Prescriber Specialty



Good Health Systems

Fax Completed Form to:
Fax Number: 800-218-3221
Phone Number: 866-843-3604

3

Department of Vermont Health Access
HUMIRA® (adalimumab)
PRIOR AUTHORIZATION REQUEST

Patient Diagnosis:

Rheumatoid Arthritis Psoriatic Arthritis Juvenile Idiopathic Arthritis

Ankylosing Spondylitis Plaque Psoriasis Crohn's Disease Ulcerative Colitis

If requesting prescriber is not a Rheumatologist, Dermatologist or Gastroenterologist, has one of these specialties been consulted on this case? Yes No

Specialist name: _____ Specialist Type: _____

List previous medications/therapies tried and failed for this condition: (include oral, injectable, topical, phototherapy etc.)

Therapy (and dates)	Reason for discontinuation

Prescriber Additional Comments: _____

4

PRESCRIPTION

Dosage Form and Quantity:

Humira 40 mg/0.8 ml (Crohn's/UC Starter kit-6) Dispense Quantity: 6 (1 kit)
 Inject 4 pens (160 mg) subcutaneously on day 1 followed by 2 pens (80 mg) on day 15, then one pen (40 mg) every other week.

Humira 40 mg/0.8 ml (Psoriasis Starter kit-4) Dispense Quantity: 4 (1 kit)
 Inject 2 pens (80 mg) subcutaneously on day 1, one (1) pen (40 mg) on day 8, then one pen (40 mg) every other week.

Humira 40 mg/0.8 ml prefilled syringe Dispense Quantity: 2 or 4
 Inject 1 syringe (40 mg) subcutaneously every other week every week (select RA ONLY)

Humira PEN 40 mg/0.8 ml Dispense Quantity: 2 or 4
 Inject 1 pen (40 mg) subcutaneously every other week every week (select RA ONLY)

Humira PED 20 mg/0.4 ml prefilled syringe Dispense Quantity: 2
 Inject 1 syringe (20 mg) subcutaneously every other week

Refill X: _____

Deliver product to: Patient's home MD office Clinic

Prescriber's Signature: _____ Date: _____