



Department of Vermont Health Access  
 NOB 1 South, 280 State Drive  
 Waterbury, Vermont 05671-1010

~Humira (Adult)~

**Prior Authorization Request Form**

In order for members to receive Medicaid coverage for medications that require prior authorization, the prescriber must complete and fax this form to Change Healthcare. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information. For questions, please contact the Change Healthcare helpdesk at 1-844-679-5363.

**Submit request via Fax: 1-844-679-5366**

**Prescribing physician:**

Name: \_\_\_\_\_  
 Physician NPI: \_\_\_\_\_  
 Specialty: \_\_\_\_\_  
 Phone#: \_\_\_\_\_  
 Fax#: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Contact Person at Office: \_\_\_\_\_

**Member:**

Name: \_\_\_\_\_  
 Medicaid ID#: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_  
 Patient's Phone: \_\_\_\_\_  
 Pharmacy Name: \_\_\_\_\_  
 Pharmacy NPI: \_\_\_\_\_  
 Pharmacy Phone: \_\_\_\_\_ Pharmacy Fax: \_\_\_\_\_

**Patient Diagnosis:**  Rheumatoid Arthritis  Psoriatic Arthritis  Juvenile Idiopathic Arthritis  Ankylosing Spondylitis  
 Plaque Psoriasis  Crohn's Disease  Ulcerative Colitis  Hidradenitis Suppurativa  Uveitis

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

Name of medication	Type of failure	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Crohn's Disease/Ulcerative Colitis/Hidradenitis Suppurativa Starter Package**

- Humira 40 mg/0.8ml PEN Kit Dispense Quantity: 6 (1 kit) Inject 4 pens (160mg) subcutaneously on day 1 followed by 2 pens (80mg) on day 15, then begin maintenance package on day 29. NDC # 00074-4339-06
- Humira 40 mg/0.4 ml PEN Kit Dispense Quantity: 6 (1 kit) Inject 4 pens (160mg) subcutaneously on day 1 followed by 2 pens (80mg) on day 15, then begin maintenance package on day 29. NDC # 00074-0554-06
- Humira 80mg/0.8ml PEN Kit Dispense Quantity: 3 (1 kit) Inject 2 pens (160mg) subcutaneously on day 1 followed by 1 pen (80mg) on day 15, then begin maintenance package on day 29. NDC # 00074-0124-03

**Plaque Psoriasis/Uveitis Starter Package**

- Humira 80mg/0.8ml + 40mg/0.4ml PEN Kit Dispense Quantity: 3 (1 kit) Inject 1 pen (80mg) subcutaneously on day 1 followed by 1 pen (40mg) on day 8, then begin maintenance package on day 22. NDC # 00074-1539-03

**Maintenance Package: Dosing Frequency**  every other week  every week

- Humira Prefilled Syringe  80 mg/0.8 ml  40 mg/0.8 ml  40mg/0.4ml
- Humira PEN  80 mg/0.8 ml  40 mg/0.8 ml  40mg/0.4ml

Prescribers Additional Comments: \_\_\_\_\_

By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in your medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.

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

