



Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Humira (adalimumab)**. Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours fax: 1-866-331-2104. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless this form is complete.**

KP-MAS Formulary can be found at: [Pharmacy | Community Provider Portal | Kaiser Permanente](#)

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Provider Information

Is the prescriber a Rheumatologist, Dermatologist, or Gastroenterologist?

No Yes

If consulted with a specialist, specialist name and specialty: _____

Provider Name: _____ Specialty: _____ NPI: _____

Provider Address: _____

Provider Phone #: _____ Provider Fax #: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone # _____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____

Sig: _____

Drug 2: Name/Strength/Formulation: _____

Sig: _____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?

Initial therapy Continuing therapy, state start date: _____

2. Indicate the patient’s diagnosis for the requested medication: _____

Clinical Criteria:

1. Does the patient have a history of treatment failure, intolerance, or contraindication to adalimumab biosimilars (Amjevita preferred)?
 No Yes
2. Has the patient had a negative test for tuberculosis within the past 12 months (prefer within the last 3 months)?
 No Yes
3. Has the patient had a negative test for hepatitis B within the past 24 months?
 No Yes

Rheumatology:**If treating psoriatic arthritis:**

1. Does the patient have a diagnosis of psoriatic arthritis?
 No Yes
2. Does the patient have a history of inadequate response after at least a 3-month trial, contraindication or intolerance to an infliximab product OR Cosentyx (secukinumab)?
 No Yes
3. Does the patient have a history of inadequate response after at least a 3-month trial, contraindication or intolerance to one or more medications to treat psoriatic arthritis such as conventional DMARDs (e.g. methotrexate or leflunomide)?
 No Yes

If treating spondyloarthropathy/spondyloarthritis:

1. Has the patient had an inadequate response, contraindication or intolerance to infliximab product (Inflectra preferred)?
 No Yes
2. Does the patient meet at least ONE of the following conditions?
 - Diagnosis of active ankylosing spondylitis or nonradiographic axial spondyloarthritis, AND has inadequate response after at least 4 weeks, contraindication, or intolerance to full anti-inflammatory dose of an NSAID taken on a regular continuing basis
 - Presence of enthesitis/tendinitis as part of manifestation of peripheral spondyloarthritis such as Achilles tendinopathy or plantar fasciitis
 - Diagnosis of peripheral spondyloarthritis (i.e. reactive arthritis, spondyloarthritis related to inflammatory bowel disease or other peripheral spondyloarthritis rather than axial), does NOT have enthesitis, AND has had inadequate response after 3-month trial, contraindication, or intolerance to at least one nonbiologic DMARD such as sulfasalazine, methotrexate or leflunomide No Yes

If treating rheumatoid arthritis:

1. Does the patient have a diagnosis of rheumatoid arthritis and documented advanced disease or high disease activity?
 No Yes
2. Has the patient had an inadequate response (after at least a 3-month minimum trial), contraindication, or intolerance to at least ONE of the following:
 - Methotrexate (oral or injectable)
 - Hydroxychloroquine
 - Leflunomide
 - Sulfasalazine No Yes

3. Does the patient have history of inadequate response after at least a 3-month trial, contraindication, or intolerance to infliximab?
 No Yes

If treating pediatrics with juvenile idiopathic arthritis:

1. Is the patient ≥ 2 years with juvenile idiopathic arthritis?
 No Yes
2. Has the patient had an inadequate response, contraindication, or intolerance to methotrexate?
 No Yes

Dermatology:

If treating plaque psoriasis in adults ≥ 18 years of age:

1. Does the patient have a diagnosis of moderate to severe plaque psoriasis ($>3\%$ body surface area unless palmar-plantar involvement is severe)?
 No Yes
2. Has the patient had an inadequate response after at least a 3-month trial or contraindication to phototherapy unless involvement in sensitive areas (e.g., face, body folds, etc.)?
 No Yes
3. Has the patient failed at least a 1-month trial of high or ultra-high potency topical corticosteroids, unless clinically significant adverse effects, contraindication or clinical reason to avoid treatment?
 No Yes
4. Has the patient failed at least a 3-month trial of **1 of the following** unless clinically significant adverse effects, contraindication or clinical reason to avoid treatment (i.e. pregnancy/breastfeeding, history of alcoholism or alcoholic liver disease, chronic liver disease, immunodeficiency syndrome, pre-existing blood dyscrasia, hemodialysis, or end-stage renal disease):
 - Methotrexate
 - Acitretin No Yes
5. Has the patient had an inadequate response, intolerance, or contraindication to Cosentyx (secukinumab)
 No Yes

If treating plaque psoriasis in pediatrics <18 years of age:

1. Does the patient have a diagnosis of moderate to severe plaque psoriasis?
 No Yes
2. Is the patient <18 years of age?
 No Yes
3. Has the patient had inadequate response, contraindication, or intolerance to topical psoriasis treatments?
 No Yes
4. Has the patient had inadequate response, contraindication, or intolerance to methotrexate OR at least a 12-week trial of phototherapy?
 No Yes

Gastroenterology:

If treating Crohn's disease or ulcerative colitis:

1. Is the patient being treated for a diagnosis of moderate to severe Crohn's disease or ulcerative colitis (UC)?
 No Yes

2. Has the patient had inadequate response, intolerance or contraindication to ALL of the following?
 - One conventional therapy [Mesalamine (UC only), azathioprine, 6-mercaptopurine, OR methotrexate],
 - Corticosteroids
 - Infliximab
 - Xeljanz (tofacitinib) – for ulcerative colitis only, not applicable to Crohn's disease No Yes

If treating other indications:

1. Is the patient being treated for ANY of the following indications, and medication is being prescribed by a specialist?
 - Hidradenitis suppurativa and <18 years of age or history of treatment failure to Amjevita
 No Yes

 - Uveitis and related conditions and <18 years of age or history of treatment failure to Amjevita
 No Yes

For continuation of therapy, please respond to additional questions below:

1. Does the patient have history of treatment failure, intolerance, or contraindication to adalimumab biosimilars (Amjevita preferred)?
 No Yes

2. Has the patient had positive clinical response to medication (i.e. asymptomatic or in clinical remission)?
 No Yes

3. Has specialist follow-up occurred in the last 12 months since last review?
 No Yes

7 – Provider Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Provider Signature:

Date:

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