Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Humira (adalimumab) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 6 months; Continuation- 12 months

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

<u>If treating pediatrics with juvenile idiopathic arthritis:</u>

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:

<u>If treating plaque psoriasis in adults ≥18 years of age:</u>

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

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

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:**