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. Member has history of treatment failure, intolerance, or contraindication to adalimumab biosimilars (Amjevita preferred), **AND**
   □ No □ Yes

Rheumatology:

1. Member has psoriatic arthritis
   □ No □ Yes

2. **AND** member has history of inadequate response after at least a 3-month trial, contraindication or intolerance to an infliximab product OR Cosentyx (secukinumab)
   □ No □ Yes

3. **AND** member has 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

OR

1. Member has a diagnosis of active ankylosing spondylitis or nonradiographic axial spondyloarthritis
   □ No □ Yes

2. **AND** member has inadequate response after at least 4 weeks, contraindication or intolerance to infliximab AND full anti-inflammatory dose of an NSAID taken on a regular continuing basis
   □ No □ Yes

OR

1. Member has documented presence of enthesitis/tendonitis as part of manifestation of peripheral spondyloarthritis
   □ No □ Yes

OR

1. Diagnosis of peripheral spondyloarthritis and does not have enthesitis/tendonitis
   □ No □ Yes

2. **AND** history of inadequate response after 3-month trial, contraindication, or intolerance of at least one nonbiologic DMARD such as sulfasalazine, methotrexate or leflunomide
   □ No □ Yes

OR

1. Diagnosis of rheumatoid arthritis
   □ No □ Yes

2. **AND** patient has had an inadequate response after at least a 3-month trial, contraindication, or intolerance to infliximab
   □ No □ Yes

3. **AND** documented advanced disease or high disease activity
   □ No □ Yes

4. **AND** intolerance, contraindication or inadequate response after a 3-month minimum trial of one of the following: oral/subcutaneous methotrexate, hydroxychloroquine, leflunomide or sulfasalazine
   □ No □ Yes

OR

5. Pediatric patients ≥2 years with juvenile idiopathic arthritis who have failed methotrexate
   □ No □ Yes

Dermatology:

1. Diagnosis of moderate to severe plaque psoriasis (>3% body surface area unless palmar-plantar involvement is severe)
   □ No □ Yes

2. **AND** member has had 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. **AND** member has 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. **AND** 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):
   a. Methotrexate
   b. Acitretin
   □ No □ Yes

5. **AND** failure, inadequate response, or intolerance to Cosentyx (secukinumab)
   □ No □ Yes

OR

1. Member has a diagnosis of moderate to severe plaque psoriasis in pediatric patients ≤17 years who have contraindication, intolerance or inadequate response to the following:
   a. Topical psoriasis treatment **AND**
      i. methotrexate **OR**
      ii. 12-week trial of phototherapy
   □ No □ Yes

AND

1. Negative test for tuberculosis within the past 12 months (prefer within the last 3 months)
   □ No □ Yes

2. **AND** negative test for hepatitis B within the past 24 months
   □ No □ Yes

Gastroenterology:

1. Member diagnosed with moderate to severe Crohn's disease or ulcerative colitis (UC)
   □ No □ Yes

2. **AND** failed, has intolerance to, or contraindication to:
   a. One conventional therapy [Mesalamine (UC only), azathioprine, 6-mercaptopurine, OR methotrexate],
   b. **AND** corticosteroids
   c. **AND** infliximab – unless member is physically located outside of our KP Network (i.e., college student) and is unable to receive infusions
   □ No □ Yes

3. For UC, must meet the same criteria OR have an inadequate response to at least a 3-month trial, intolerance, and/or contraindication to Xeljanz.

□ No □ Yes

Other Indications:

1. Member is being treated for any of the following labeled indications **AND** prescribed by a specialist:
    a. Hidradenitis suppurativa
    □ No □ Yes

    b. Uveitis and related conditions
    □ No □ Yes

For continuation of therapy, please respond to <u>additional questions</u> below:

1. Member continues to meet initial review criteria for Humira,
    □ No □ Yes

2. **AND** member has positive clinical response to medication (i.e. asymptomatic or in clinical remission)
    □ No □ Yes

3. **AND** 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:**