CVS CAREMARK

Fax Referral To: 800-323-2445
Phone: 866-278-6634

Humira® (adalimumab)
Enrollment Form
For Blue Cross Blue Shield of Rhode Island Members

Date: _____ **Needs by Date (Please Specify):** _____

Ship to: ☐ **Patient** ☐ **Office** ☐ **Other:** _____

PATIENT INFORMATION

*(Complete the following or **send patient demographic sheet**)*

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Alternate Phone: _____
SS #: _____
Insurance ID: _____
Date of Birth: _____ Gender: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ UPIN: _____
DEA #: _____ NPI #: _____
Group or Hospital: _____
Address: _____
City, State Zip: _____
Phone: _____ Fax: _____
Contact Person: _____
Contact Phone: _____

INSURANCE INFORMATION *(If available, please copy and attach the front and back of insurance and prescription drug card)*

Primary Insurance: Subscriber: _____ Subscriber ID#: _____ Name of Insurer: **Blue Cross Blue Shield of RI**

Secondary Insurance: Subscriber: _____ Subscriber ID#: _____ Name of Insurer: _____

STATEMENT OF MEDICAL NECESSITY for BCBS of Rhode Island Members

Diagnosis (ICD-9 Code):
☐ 714.0 Rheumatoid Arthritis ☐ 696.0 Psoriatic Arthritis • Date of Diagnosis: _____
☐ 555.0 Regional Enteritis or Crohn's Disease of Small Intestine ☐ 555.9 Regional Enteritis or Crohn's Disease NOS
☐ 555.1 Regional Enteritis or Crohn's Disease of Large Intestine ☐ Other: _____

APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY.

NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

- Patient has a latex allergy ☐ Yes ☐ No
- Patient has tuberculosis or a history of recurrent, chronic current, or clinically important infection ☐ Yes ☐ No
- Patient had a tuberculin skin test to rule out latent tuberculosis ☐ Yes ☐ No
- Patient with CHF developed new symptoms or worsening symptoms of pre-existing CHF ☐ Yes ☐ No
- Patient has Multiple Sclerosis or any other demyelinating disease ☐ Yes ☐ No
- Humira will be used in combination with other TNF agents or Kineret ☐ Yes ☐ No
- Patient is currently receiving systemic psoriasis therapy (except for methotrexate, glucocorticoids, salicylates, non-steroidal anti-inflammatory drugs, or analgesics), immunosuppressive therapy, or Anakinra ☐ Yes ☐ No
  - Comments: _____
- Patient is pregnant or nursing ☐ Yes ☐ No
- Patient is less than 18 years of age ☐ Yes ☐ No
- Patient is currently taking Humira ☐ Yes ☐ No If yes, please indicate date started: _____

Ankylosing Spondylitis:

- Patient is 18 years of age or older ☐ Yes ☐ No
- Patient has failed, had an inadequate response to or is not indicated for treatment with sulfasalazine, methotrexate, or non-steroidal anti-inflammatory drugs ☐ Yes ☐ No

Rheumatoid Arthritis:

- Patient must be 18 years of age or older ☐ Yes ☐ No
- Patient must have symptoms of moderately to severely active rheumatoid arthritis ☐ Yes ☐ No
- Patient has failed or had an inadequate response to one or more of the following disease-modifying anti-rheumatic agents (DMARD): ☐ Yes ☐ No

☐ Azathioprine (Imuran) ☐ Hydroxychloroquine (Plaquenil)
☐ Methotrexate ☐ Auranofin (Ridaura)
☐ Penicillamine (Cuprimine, Depen) ☐ Sulfasalazine (Azulfidine)
☐ Cyclophosphamide (Cytoxan or Neosar) ☐ Cyclosporine (Neoral or Sandimmune)
☐ Minocycline (Minocin or Dynacin) ☐ Leflunomide (Arava)
☐ Gold Sodium Thiomalate (Myochrysine)

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Psoriatic Arthritis:

- Patient has active arthritis with at least 3 swollen joints AND 3 tender joints ☐ Yes ☐ No
- Patient present plaque psoriasis with a qualifying target lesion at least 2cm in diameter ☐ Yes ☐ No
- Patient has arthritis in any of the following distributions: ☐ Yes ☐ No

☐ Arthritis Mutilans ☐ Asymmetric Arthritis ☐ Ankylosing Spondylitis-like Arthritis

☐ Distal Interphalangeal Joint Involvement ☐ Polyarticular Arthritis, without Rheumatoid Nodules

- Patient has failed or had an inadequate response to one or more of the following disease-modifying anti-rheumatic agents (DMARD), specifically methotrexate or sulfasalazine:

☐ Yes ☐ No

☐ Azathioprine (Imuran)
☐ Hydroxychloroquine (Plaquenil)
☐ Methotrexate
☐ Auranofin (Ridaura)
☐ Penicillamine (Cuprimine, Depen)
☐ Sulfasalazine (Azulfidine)
☐ Cyclophosphamide (Cytoxan or Neosar)
☐ Cyclosporine (Neoral or Sandimmune)
☐ Minocycline (Minocin or Dynacin)
☐ Leflunomide (Arava)
☐ Gold Sodium Thiomalate (Myochrysine)

- Is the patient currently receiving systemic therapy for psoriatic arthritis (**except** methotrexate, glucocorticoids, salicylates, non-steroidal anti-inflammatory drugs or analgesics), Immunosuppressive therapy, or Kineret (anakinra)? ☐ Yes ☐ No
- Is the patient a pregnant woman or a nursing mother? ☐ Yes ☐ No

Juvenile Idiopathic Arthritis (JIA):

- Patient is at least 4 years of age ☐ Yes ☐ No
- Patient has a diagnosis of moderate to severe polyarticular juvenile idiopathic arthritis ☐ Yes ☐ No

Crohn's Disease:

- Patient has had an inadequate response to conventional therapy (ex. sulfasalazine, oral mesalamine, corticosteroids, and antibiotics) ☐ Yes ☐ No

Chronic Moderate to Severe Plaque Psoriasis:

- Patient is 18 years of age or older ☐ Yes ☐ No
- The patient's disease is controlled with topical therapy ☐ Yes ☐ No
- Patient has failed, has a contraindication, or is intolerant to, but is otherwise a candidate for other systemic therapies (e.g. methotrexate, acitretin, or cyclosporine) or phototherapy ☐ Yes ☐ No
- **What is the percent** of body surface area that is affected with Plaque Psoriasis

☐ Greater than 10%

☐ Less than 10% involving sensitive areas or areas that impact daily function (head, neck, palms, soles of feet, genitalia)

☐ Other: _____

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Humira® (adalimumab)	☐ Crohn's Starter Package ☐ Psoriasis Starter Package ☐ 40mg Self Injectable Pen ☐ 40mg Prefilled Syringe	Dosing Requested: ☐ Every other week (2 vials per 28 days) ☐ Once weekly (4 vials per 28 days) ☐ For Moderate to Severe Rheumatoid Arthritis: Once weekly dosing (4 vials per 28 days) if patient is NOT taking concomitant methotrexate. ☐ Crohn's Disease: Induction Dose: Inject subcutaneously 160mg (4 pens) on day 1, then 80mg (2 pens) on day 15, then maintenance dosing. ☐ Chronic Moderate to Severe Plaque Psoriasis: 80mg **one time only** as initial dose followed by 40mg every other week starting one week after initial dose.		

PRODUCT SUBSTITUTION PERMITTED (Date)

DISPENSE AS WRITTEN (Date)

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