



Would you like to use electronic prior authorization? Consider using Surescripts, our electronic prior authorization portal at providerportal.surescripts.net/ProviderPortal/login OR fax completed prior authorization request form to 800-750-9692.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at sentarahealthplans.com/en/providers/authorizations/prescription-drugs

Adalimumab (Medicare)

REQUIRED: Office notes, labs, and medical testing relevant to request showing medical justification to support diagnosis

Member Information

Member Name (first & last):	Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Height:
Member ID:	City:	State:	Weight:

Prescribing Provider Information

Requestor's Name:	Requestor's Phone Number:	Requestor's Fax Number:	
Provider Name (first & last):	Specialty	NPI:	DEA:
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone:	Office Fax:	

Dispensing Provider/Pharmacy Information

Place of Administration:	<input type="checkbox"/> Self-Administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Home <input type="checkbox"/> Home Infusion Center <input type="checkbox"/> Outpatient Infusion Center Name: _____	
Agency NPI:	Agency Name:	Agency Phone Number:
Agency Address	Agency Fax Number:	
City:	State:	Zip:
Dispensing Location:	<input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Mail Order <input type="checkbox"/> Physician's Office <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Other	
Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:
Pharmacy NPI:		

Requested Medication Information

Medication request is NOT for an FDA approved, or compendia-supported diagnosis (check one): <input type="checkbox"/> Yes <input type="checkbox"/> No	Diagnosis:	ICD-10 Code:	
Are there any contraindications to formulary medications? If yes, please specify:	Is this a New Request or Continuation of Therapy: <input type="checkbox"/> New, start date: __/__/____ <input type="checkbox"/> Continuation, date of last treatment: __/__/____		
Directions for Use:	Strength:	Dosage Form	
	Duration:	Quantity:	Days Supply:

What medication(s) has the member tried and failed for this diagnosis? Please specify below including duration of treatment.

Turn-Around Time for Review:

☐Standard ☐Urgent: Waiting standard time for decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision.

Signature: _____



Health Plans Member First Name: _____ Member Last Name: _____

Member ID: _____ Member Date of Birth: _____

Clinical Information:

** Indicate questions that are required to be answered*

Q1. For Reauthorization: Has the member responded positively to therapy as determined by the prescribing physician?

☐ Yes

☐ No

Q2. Please select applicable diagnosis: *

☐ Ankylosing Spondylitis (AS)

☐ Polyarticular Juvenile Idiopathic Arthritis (PJIA)

☐ Crohn's Disease (CD)

☐ Psoriatic Arthritis (PsA)

☐ Hidradentis Suppurativa (HS)

☐ Rheumatoid Arthritis (RA)

☐ Juvenile Psoriatic Arthritis (JPsA)

☐ Ulcerative Colitis (UC)

☐ Juvenile Rheumatoid Arthritis (JRA)

☐ Uveitis

☐ Plaque Psoriasis (PsO)

Q3. For all diagnoses: Will the medication be used concomitantly with other biologics, targeted synthetic DMARDs, potent immunosuppressants, anti-interleukin monoclonal antibodies, or janus kinase (JAK) inhibitors?

☐ Yes

☐ No

Q4. For all diagnoses: Has the medication been prescribed by or in consultation with one of the following:

☐ RA/AS/JIA/JRA: Rheumatologist

☐ PsA: Rheumatologist or dermatologist

☐ PsO and HS: Dermatologist

☐ UC/CD: Gastroenterologist.

☐ UV: Ophthalmologist

☐ None of the above

Q5. For all diagnoses: Is the member's disease moderately to severely active?

☐ Yes

☐ No

Q6. For all diagnoses: Will latent tuberculosis (TB) test prior to starting treatment and monitoring for active TB throughout treatment even if initial latent TB test is negative?

☐ Yes

☐ No

Q7. For CD: Does the member have evidence of large or deep ulcers, strictures, or extensive areas of disease and/or evidence of stricturing, penetrating, or perianal disease on endoscopy?

☐ Yes

☐ No

Q8. For AS: Does the member have signs and symptoms of active disease (i.e. back pain and stiffness in the lower back and hips, neck pain and fatigue, skin rashes)?



Health Plans Member First Name: _____ Member Last Name: _____

Member ID: _____ Member Date of Birth: _____

☐ Yes

☐ No

Q9. For PsA/JPsa: Has documentation been sent showing the presence of at least one of the following: actively inflamed joints, dactylitis, enthesitis, axial disease, active skin or nail involvement, or extraarticular manifestations such as uveitis or inflammatory bowel disease (IBD)?

☐ Yes

☐ No

Q10. For UC: Which of the following does the member have:

- ☐ Member presents with frequent, bloody stools that occur 6 or more times daily or frequent and heavy rectal bleeding
- ☐ Member has severe inflammation or ulcers as visualized on endoscopy
- ☐ None of the above