HEALTH PLANS
UNIVERSITY OF UTAH

PRIOR AUTHORIZATION REQUEST FORM
HIDRADENITIS SUPPURATIVA
Humira®

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 888-509-8142. Failure to submit clinical documentation to support this request will result in delay and/or denial of the request.

If you have prior authorization questions, please call for assistance: Healthy U: 855-856-5694, University of Utah Health Employees: 855-856-5690, Individual & Family Plans : 855-869-4769, Commercial Groups: 855-859-4892, MHC 855-885-7695

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Humira® (adalimumab)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Does the member have a diagnosis of moderate to severe (Hurley Stage II or III) Hidradenitis Suppurativa?	☐	☐	**Please provide documentation**
2. Is the requesting provider a dermatologist or in consultation with a dermatologist?	☐	☐	
3. Has smoking cessation, weight management, diet, and proper hygiene counseling been discussed with the member?	☐	☐	**Please provide documentation**
4. Has the member had an inadequate response to ≥ 90 day trial of oral antibiotics, unless contraindicated?	☐	☐	**Please provide documentation**
5. Have baseline inflammatory lesion count (abscesses + inflammatory nodules) and draining fistulas been documented?	☐	☐	**Please provide documentation**
6. Has the provider performed tuberculosis (TB) screening prior to therapy initiation?	☐	☐	**Please provide documentation**
7. Has the provider performed hepatitis B screening prior to therapy initiation?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has a Hidradenitis Suppurativa Clinical Response been seen by week 16 of therapy, defined as a ≥50% decrease in inflammatory lesion count (abscesses + inflammatory nodules) and no increase in abscesses or draining fistulas compared to baseline?	☐	☐	**Please provide documentation**

3. Has the provider performed continued tuberculosis monitoring during therapy?	☐	☐	**Please provide documentation**
4. Has the provider performed continued Hepatitis B monitoring in HBV carriers?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:

Physician's Signature:

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Policy PHARM- 032
Origination Date: 05/10/2018
Reviewed/Revised Date: 01/27/2021
Next Review Date: 01/27/2022
Current Effective Date: 02/01/2021