

**PRIOR AUTHORIZATION REQUEST FORM
 HUMIRA® FOR UVEITIS**

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:

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® (generic)

Dosing/Frequency: _____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Is the member 2 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is the requesting provider an ophthalmologist or in consultation with one?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Has the member been diagnosed with non-infectious uveitis classified as intermediate, posterior, or panuveitis?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Has the member had a trial and failure of at least 1 corticosteroid at the maximum indicated dose?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
5. Has the member had a trial and failure of at least 1 systemic non-biologic immunosuppressant (methotrexate, cyclosporine, azathioprine, mycophenolate, etc.) within the last 3 months?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
6. Will Humira be used in combination with any other biologic or small molecule DMARD (Xeljanz, Otezla, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	

REAUTHORIZATION

1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Does documentation show a positive clinical response to treatment?	<input type="checkbox"/>	<input type="checkbox"/>	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.

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Additional information:

Physician Signature:

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Policy: PHARM- 101
Origination Date: 06/18/2020
Reviewed/Revised Date: 08/19/2020
Next Review Date: 08/19/2021
Current Effective Date: 09/01/2020

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