

1 PATIENT INFORMATION:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Alt. Phone: _____
Email: _____
DOB: _____ Gender: M F Caregiver: _____
Height: _____ Weight: _____ Allergies: _____

2 PRESCRIBER INFORMATION:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____
NPI: _____ DEA: _____
Tax I.D.: _____
Office Contact: _____ Phone: _____

3 STATEMENT OF MEDICAL NECESSITY: (Please Attach All Medical Documentation)

Date of Diagnosis: _____ ICD-10: _____
Other: _____
TB Test: Positive Negative Date: _____
Serious or active infection present? Yes No
Hep B ruled out or treatment started? Yes No
Does patient have latex allergy? Yes No

Prior Failed Treatments:

- 5-ASA
- Biologics
- Corticosteroids
- Immunosuppressants
- Methotrexate
- NSAIDS
- Surgery
- Topical/Oral Antibiotics
- UVA UVB
- Others

Indicate Drug Name and Length of Treatment:

If Prior Authorization is denied, recommended formulary alternatives will be provided to the prescriber based upon the patient's insurance coverage.

4 INJECTION TRAINING: To Be Administered by Pharmacist Pharmacist to Provide Training Patient Trained in MD Office Manufacturer Nurse Support

5 PICK UP OR DELIVERY: Delivery to Patient's Home Delivery to Physician's Office Pharmacy to Coordinate

6 INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

PRESCRIPTION INFORMATION: (Please be sure to choose both induction and maintenance dose where applicable)

Patient Name: _____ Patient's Date of Birth: _____

Medication	Dosage & Strength	Direction	QTY	Refills
<input type="checkbox"/> HUMIRA®	Hidradenitis Suppurativa <input type="checkbox"/> 40mg/0.4ml Pen <input type="checkbox"/> 40mg/0.4ml Prefilled Syringe <input type="checkbox"/> 40mg/0.8ml Pen <input type="checkbox"/> 40mg/0.8ml Prefilled Syringe <input type="checkbox"/> 80mg/0.8ml Pen <input type="checkbox"/> 80mg/0.8ml Prefilled Syringe	<input type="checkbox"/> Induction Dose: <input type="checkbox"/> Adolescents 12 years and older 66 lbs to <132 lbs: Inject 80mg SC on day 1, then 40mg SC on day 8 <input type="checkbox"/> Adolescents 12 years and older >132 lbs: Inject two 80mg pens SC on day 1, then one 80mg pen SC on day 15, then 40mg on day 29 <input type="checkbox"/> Adolescents 12 years and older >132 lbs: Inject one 80mg pen SC on day 1, then 80mg pen SC on day 2, then one 80mg pen SC on day 15 <input type="checkbox"/> Maintenance Dose: <input type="checkbox"/> Adolescents 12 years and older 66 lbs to <132 lbs: Inject 40mg every other week <input type="checkbox"/> Adolescents 12 years and older >132 lbs: Inject 40mg every week		
<input type="checkbox"/> HUMIRA®	Juvenile Idiopathic Arthritis + Pediatric Uveitis <input type="checkbox"/> 10mg/0.1ml Prefilled Syringe <input type="checkbox"/> 20mg/0.2ml Prefilled Syringe <input type="checkbox"/> 40mg/0.4ml Pen <input type="checkbox"/> 40mg/0.4ml Prefilled Syringe <input type="checkbox"/> 40mg/0.8ml Pen <input type="checkbox"/> 40mg/0.8ml Prefilled Syringe	<input type="checkbox"/> 22 lbs to <33 lbs: Inject 10mg SC every other week <input type="checkbox"/> 33 lbs to <66 lbs: Inject 20mg SC every other week <input type="checkbox"/> >= 33 lbs: Inject 40mg SC every other week	2	
<input type="checkbox"/> HUMIRA®	Pediatric Crohn's Disease <input type="checkbox"/> 20mg/0.2ml Prefilled Syringe <input type="checkbox"/> 40mg/0.4ml Pen <input type="checkbox"/> 40mg/0.4ml Prefilled Syringe <input type="checkbox"/> 40mg/0.8ml Pen <input type="checkbox"/> 40mg/0.8ml Prefilled Syringe <input type="checkbox"/> Pediatric Crohn's Starter Pack: 80mg/0.8ml, 40mg/0.4ml (pack of 2) <input type="checkbox"/> Pediatric Crohn's Starter Pack: 80mg/0.8ml (pack of 3)	<input type="checkbox"/> Induction Dose: <input type="checkbox"/> 37 lbs to <88 lbs: Inject one 80mg pen SC on day 1, then one 40mg pen SC on day 15 <input type="checkbox"/> >88 lbs: Inject two 80mg pens SC on day 1, then one 80mg pen SC on day 15 <input type="checkbox"/> >88 lbs: Inject one 80mg pen SC on day 1, then 80mg pen SC on day 2, then one 80mg pen SC on day 15 <input type="checkbox"/> Maintenance Dose: <input type="checkbox"/> 37 lbs to <88 lbs: Inject 20mg SC every other week <input type="checkbox"/> >88 lbs: Inject 40mg SC every week All strengths and dosages listed are Humira® Citrate Free		
<input type="checkbox"/>				

PRESCRIBER SIGNATURE: I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: _____ Date: _____ Signature: _____ Date: _____

Substitution Permitted

Dispense As Written

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

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