

PHYSICIAN PRIOR AUTHORIZATION REQUEST FORM BlueCross[®] BlueShield[®] of South Carolina

Patient Information	
Name:	Insurance ID #:
Group #:	Birthdate:

Provider Information	
Physician's Name:	Physician DEA #:
Phone:	Fax:
Office Address:	
Diagnosis:	ICD-9 Code:

When this form is complete, please fax to Caremark at 888-836-0730.

This fax machine is in a HIPAA-compliant, secure location. On behalf of BlueCross BlueShield of South Carolina, Caremark assists in the administration of prescription drug programs. Caremark is an independent company that provides pharmacy benefits management.

Call Caremark at 800-294-5979 with any questions concerning prior authorization procedures.

1. Is the physician purchasing and providing the drug "incident to" physician services? Y N
2. Is the patient 18 years of age or older?
[If the answer to this question is no, skip to question 13.] Y N
3. At the initiation of therapy, did the patient have a diagnosis of moderately or severely active rheumatoid arthritis as the reason for requesting Humira?
[If the answer to this question is yes, skip to question 14.] Y N
4. At the initiation of therapy, did the patient have the diagnosis of active psoriatic arthritis as the reason for requesting Humira?
[If the answer to this question is yes, skip to question 15.] Y N
5. At the initiation of therapy, did the patient have a diagnosis of active ankylosing spondylitis as the reason for requesting Humira?
[If the answer to this question is no, skip to question 9.] Y N
6. Has the patient had an inadequate response to at least two non-steroidal anti-inflammatory drugs (NSAIDs) or an intolerance to multiple NSAID drugs? Y N
7. Does the patient have predominantly peripheral arthritis symptoms? Y N

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[If the answer to this question is no, skip to question 15.]

8. If indicated, did the patient have an inadequate response or an intolerance to or a contraindication to sulfasalazine?
[Skip to question 15.] Y N
9. At the initiation of therapy, did the patient have a diagnosis of moderately to severely active Crohn`s disease as the reason for requesting Humira?
[If the answer to this question is no, skip to question 12.] Y N
10. Has the patient received Humira as a Caremark benefit for at least six months and demonstrated reduced signs and symptoms or achieved clinical remission of the Crohn`s disease?
[If the answer to this question is yes, skip to question 20.] Y N
11. Did the patient have an inadequate response to conventional therapy for Crohn`s disease [i.e., prednisone, budesonide, sulfasalazine (Azulfidine), azathioprine (Imuran), mesalamine (Asacol or Pentasa) or infliximab (Remicade)]?
[If the answer to this question is yes, skip to question 16.] Y N
12. At the initiation of therapy, did the patient have a diagnosis of chronic moderate to severe plaque psoriasis (sufficiently severe to consider systemic therapy or phototherapy) as the reason for requesting Humira?
[If the answer to this question is yes, skip to question 15.] Y N
13. At the initiation of therapy, did the patient have the diagnosis of moderately to severely active polyarticular (with multiple joint involvement) juvenile idiopathic arthritis [JIA, also referred to as juvenile rheumatoid arthritis (JRA) as the reason for requesting Humira]?
[If the answer to this question is no, no further questions are required.] Y N
14. Has the patient tried and had an inadequate response to at least one or more disease-modifying antirheumatic drugs (DMARDs) [e.g., methotrexate (MTX), Imuran (azathioprine), Ridaura (oral gold), Plaquenil (hydroxychloroquine), Cuprimine (D-penicillamine), Azulfidine (sulfasalazine), Arava (leflunomide)], or does the patient have an intolerance or contraindication to multiple DMARDs? Y N
15. Is the patient currently receiving, or has in the past received, Humira therapy through a Caremark administered benefit?
[If the answer to this question is yes, skip to question 20.] Y N
16. Was the presence of latent tuberculosis ruled out (i.e., TB skin testing, etc.) prior to initiation of this drug? Y N
17. Does the patient have an active infection?
[If the answer to this question is yes, no further questions are required.] Y N
18. Is the patient receiving a biologic response modifier, either a tumor necrosis factor (TNF) blocking agents other than Humira (e.g., Cimzia, Enbrel, Remicade), selective co-stimulation modulator (e.g., Orencia), interleukin-1 (IL-1) receptor antagonist (e.g., Kineret) or monoclonal antibody to B cells (e.g., Rituxan)?
[If the answer to this question is no, skip to question 20.] Y N
19. Will the biologic response modifier be discontinued?
[If the answer to this question is no, no further questions are required.] Y N
20. Has the prescriber assessed the patient`s risk of hepatitis B, and if appropriate, tested for hepatitis B? Y N

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Comments: _____

Information on this form is accurate as of the date below.

Prescriber's Signature:	Date:
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