



Complete Patient and Physician information (PLEASE PRINT)

STEP 1	Member Name:	Physician Name:
	Address:	Address:
	Member ID:	Phone #:
	Member DOB:	Fax #:

If Applicable: Pharmacy Name: _____
Pharmacy Phone: _____

Complete the Clinical Assessment:

STEP 2	Diagnosis	<input type="checkbox"/> Moderate to Severe active Rheumatoid Arthritis <input type="checkbox"/> Psoriatic Arthritis <input type="checkbox"/> Ankylosing Spondylitis <input type="checkbox"/> Moderate to Severe Crohn's Disease <input type="checkbox"/> Moderate to Severe Chronic Plaque Psoriasis
	Clinical Consideration	For Crohn's Disease, patients should have moderate to severely active disease and be refractory to conventional therapy. <input type="checkbox"/> Patient has tried conventional therapy. Please indicate which: _____
	Physician Specialty	<input type="checkbox"/> Rheumatology <input type="checkbox"/> Physician experienced with Humira therapy <input type="checkbox"/> Other (please state): _____
	Supporting Documentation	Diagnosis: ICD-9 Code #/ Description (required): Please attach a copy of the prescription or provide ALL of the information below: Humira® (adalimumab) Strength _____ Sig _____ Qty _____ Refills _____ Please attach all relevant medical records and test results. <p style="text-align: center;">Incomplete forms will not be processed.</p>

I certify that the above is correct and accurate to the best of my knowledge (please sign and date).

STEP 3 _____ Date _____
Prescriber Signature

STEP 4 **Fax completed form to the Rocky Mountain Health Plans Pharmacy Help Desk:
970-248-5034**

Pharmacy Technician initials _____ Date Initiated _____

Confidentiality Notice:

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