Humira® (adalimumab) Prior Authorization Form

ROCKY MOUNTAIN HEALTH PLANS®
We understand Colorado. We understand you.

Complete Patient and Physician information (PLEASE PRINT)

STEP 1

Member Name:	Physician Name:
Address:	Address:
Member ID:	Phone #:
Member DOB:	Fax #:
	Tax ID or NPI Number

If Applicable: Pharmacy Name: _____
Pharmacy Phone: _____

Complete the Clinical Assessment:

STEP 2

Diagnosis	☐ Moderate to Severe active Rheumatoid Arthritis ☐ Psoriatic Arthritis ☐ Ankylosing Spondylitis ☐ Moderate to Severe Crohn's Disease ☐ 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. ☐ Patient has tried conventional therapy. Please indicate which: _____
Physician Specialty	☐ Rheumatology ☐ Physician experienced with Humira therapy ☐ Other (please state): _____
Supporting Documentation	Diagnosis: ICD-9 Code #/ Description / J Code (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. **Incomplete forms will not be processed.**

STEP 3

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

_____ _____
Prescriber Signature Date

STEP 4

Fax completed form to the Rocky Mountain Health Plans Pharmacy Help Desk:

970-248-5034

Name of Person filling out form: _____

Pharmacy Technician initials _____ Date Initiated _____

Confidentiality Notice:

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