

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM
HUMIRA (adalimumab)

Patient name: _____ Medicaid or SS# _____
Physician Name: _____ Contact person: _____
Phone#: _____ Ext.and options _____ Fax# _____
Pharmacy _____ Pharmacy Phone#: _____
Diagnosis _____

All information to be legible, complete and correct or form will be returned

**FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF
MEDICAL NECESSITY TO (801) 536-0477**

CRITERIA:

- ▶ Documented diagnosis of moderate to severely active Crohn's Disease.
- ▶ Documented inadequate response to conventional therapy (i.e. 5-aminosalicylates, antibiotics, MTX, 6-mercaptopurine, azathioprine, corticosteroids, or budesonide).

OR

- ▶ Documented intolerance to or loss of response on infliximab (Remicaid).

AUTHORIZATION:

Initial prior is for 6 months for one 6-syringe starter pack and 2-syringe maintenance packs monthly thereafter.

RE-AUTHORIZATION:

Six months of 2-syringe maintenance packs with updated letter of medical necessity.

