Health New England
Medication Request Form (MRF)/Prescription Request
Humira® (adalimumab)

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Contacted:
Physician:
Pharmacy:
Patient:

Prior Authorization

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Approved:
Quantity approved:
PA from and thru date:
PA #
Denied:
Returned:

Instructions:

This form is to be used by participating physicians and pharmacy providers to obtain coverage of Humira®. Please complete this form and fax to ICORE Healthcare at **(866) 364-2673**. If you have any questions regarding this process, please contact ICORE Healthcare at **(800) 775-5138**.

J-Codes: **Humira®** J0135, unit = 20mg (if administered in physicians office only)

Medication Request Information (please complete each section of this form prior to transmittal):

Patient Information	Physician Information
Patient Name (required):	**Physician Name (required):** **Specialty (required):**
Patient Cell Phone #: ( ) -	**NPI #:**
Patient HNE ID# (required):	**HNE Provider #:**
Patient Date of Birth (required):	**DEA # (required):**
Allergies:	**Telephone #: ( ) -**
Diagnosis (required):	**Fax # (required): ( ) -**

Drug Information

Preferred Drug/Strength/Form: Humira □ Pre-filled Syringe □ Pen

Dose, Directions, and length of treatment (please be specific):	Quantity (per month):	Refills:

Physician Signature: **Date:**

Indication:

- ☐ Moderate to Severe Rheumatoid Arthritis.
- ☐ Psoriatic Arthritis
- ☐ Diagnosis of Ankylosing Spondylitis
- ☐ Crohn's Disease
- ☐ Juvenile Idiopathic Arthritis
- ☐ Plaque Psoriasis (moderate to severe)
- ☐ Other (please describe): ____________________

Documentation of Medical Necessity (*check all that apply*):

- ☐ Patient has been seen by a Rheumatologist within the previous 12 months.
- ☐ Request is for continuation of therapy
- ☐ Patient is intolerant to or failed therapy of at least one (1) DMARD or immunomodulator (including methotrexate, sulfasalazine, hydroxychloroquine, aurothioglucose, auranofin, gold sodium thiomalate, azathioprine, d-penicillamine, cyclosporine, infliximab, etanercept, leflunomide, or anakinra).
- ☐ Patient is steroid dependent (for Crohn's Disease)
- ☐ Active infections have been excluded (required). (including but not limited to chronic or localized infections, histoplasmosis, cytomegalovirus, tuberculosis, HIV)
- ☐ Pregnancy has been excluded or if female is of child-bearing age appropriate contraception is being utilized (use with caution)
- ☐ The patient will not receive another tumor necrosis factor medications (TNF) such as Enbrel (etanercept), Kineret (anakinra) or Remicade (infliximab) or Arava (leflunomide)
- ☐ Other pertinent history: ____________________