

1 PATIENT INFORMATION:

Name: _____
Address: _____
City: _____ State: ____ Zip: _____
Phone: _____ Alt. Phone: _____
Email: _____
DOB: _____ Gender: M F Caregiver: _____
Height: _____ Weight: _____ Allergies: _____

2 PRESCRIBER INFORMATION:

Name: _____
Address: _____
City: _____ State: ____ Zip: _____
Phone: _____ Fax: _____
NPI: _____ DEA: _____
Tax I.D.: _____
Office Contact: _____ Phone: _____

3 STATEMENT OF MEDICAL NECESSITY: (Please Attach All Medical Documentation)

Date of Diagnosis: _____ Serious or active infection present? Yes No
ICD-10: _____ Does patient have latex allergy? Yes No
Other: _____ Hep B ruled out or treatment started? Yes No
History of malignancy? Yes No
TB Test: Positive Negative Date: _____ History of MS or other demyelinating disease? Yes No
New onset CHF or worsening CHF? Yes No
Contraindication for antibiotics? Yes No

Prior Failed Treatments: **Indicate Drug Name and Length of Treatment:**

Antibiotics _____
 Steroid Injections _____
 Immunosuppressants _____
 Methotrexate _____
 Others _____

If Prior Authorization is Denied:

- Automatically Draft Appeal for Review
- Send Preferred Formulary Alternatives

4 PRESCRIPTION INFORMATION: (Please be sure to choose both induction and maintenance dose where applicable)

Medication	Dosage & Strength	Direction	QTY	Refills
<input type="checkbox"/> HUMIRA®	<input type="checkbox"/> Uveitis Starter Pack	<input type="checkbox"/> Induction Dose: Inject 80mg SC on day 1, then 40mg SC on day 8, then 40mg SC every other week	4	0
	<input type="checkbox"/> 40mg/0.8ml Pen <input type="checkbox"/> 40mg/0.8ml Prefilled Syringe	<input type="checkbox"/> Maintenance Dose: Inject 40mg SC every other week <input type="checkbox"/> Other: _____ <input type="checkbox"/> Patient has signed HUMIRA Complete form	2	
<input type="checkbox"/> _____	_____	_____		
<input type="checkbox"/> _____	_____	_____		
<input type="checkbox"/> _____	_____	_____		

5 INJECTION TRAINING: Pharmacist to Provide Training Patient Trained in MD Office Manufacturer Nurse Support

6 PRODUCT DELIVERY: Patient's Home Physician's Office Pharmacy to Coordinate

7 INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

8 PRESCRIBER SIGNATURE: I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: _____ Date: _____ Signature: _____ Date: _____

Substitution Permitted

Dispense As Written

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

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