



Physician's Prior Authorization Questionnaire
Humira®

Patient:

ID#:

DOB:

Patient Address:

Humira® is covered under certain clinical conditions. The following information will help determine if this patient is eligible for coverage of treatment with this drug.

- 1. What is this patient's diagnosis? (Please do not use codes.)
2. If the patient is a child, please list the child's current weight in kilograms:
3. Please detail the clinical course and current state of disease progression.
4. Please list the medications that have been tried, the duration and a brief description of the type of failure:
5. What is the patient's current Rx therapy?
6. What is the duration of present Rx therapy?
7. Is the patient currently experiencing a failed therapy?
8. Has Methotrexate been attempted?
9. Please clarify current therapy failures on slow-acting agents with explanation as to why this patient requires Humira®:
10. How long do you anticipate this treatment to last?

Humira® will be shipped to the patient from our Specialty Pharmacy.

Physician's Signature

Date

Please Print Physician's Name & Specialty

Phone Number

Fax Number

Thank you for your assistance and should you have any questions or wish to discuss, please feel free to contact the pharmacy department at (501) 378-3392. For your convenience, you may fax your response(s) back to (501) 378-6980.

Forms are also available online at www.usableadmin.com/providers/PharmacyForms.aspx