

ADALIMUMAB PRIOR APPROVAL REQUEST

Send completed form to: Service Benefit Plan Prior Approval P.O. Box 52080 MC 139 Phoenix, AZ 85072-2080 Attn. Clinical Services Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)				Provider Information (required)				
Date:					Provider Name:			
Patient Name:					Specialty:		NPI:	
Date of Birth:		Sex:	Male	□Female	Office Phone:		Office Fax:	
Street Address:					Office Street Address	ss:	1	
City:		State:		Zip:	City:	S	tate:	Zip:
Patient ID: R	<u> </u>			1	Physician Signature:	 		
K			P	HYSICIAN	COMPLETES			
		NOTE. I				, man a a a a a in a		
		NOTE: I	TOTHI III	ust be comple	ted in its entirety for	r processing		
Please select me				. 5/ 11			11 / 1 11	
□Abrilada (ad □Amjevita (ad		tta)		io □(adalim nira (adalim			di (adalimuma a (adalimuma	-
□Cyltezo (ada					alimumab-adaz)	-	y (adalimuma) y (adalimuma)	•
□Hadlima (ad			•	cio (adalimur			, (www	~
**Check www.fepbl								
□ YES – this	is a PA renew		NUAT	ION of therap	ot 6 months excluding by, please answer the estions below:			r below:
2. Is this request	for brand or g	generic? □Bra	and 🗆	Generic				
•	as the result o	of the test positi	ive or n	egative for TE	s* □No B infection? □Positive patient currently rece	•		□Yes □No
4. Is the patient **If YES, had infection?	as hepatitis B	virus (HBV) in			Yes* □No at or has the patient a	lready started	treatment for H	BV
5. Does the patie	ent have any a	ctive infections	s includ	ling tuberculo	sis (TB) or hepatitis l	B virus (HBV)	? □Yes □N	lo
6. Will the patie	nt be given liv	ve vaccines whi	ile on tl	nis therapy?	⊒Yes □No			
* <i>If YES</i> , pl	lease specify t	he medication:			gic *DMARD or targ			
					elx, Cimzia, Cosentyx, I a. Remicade, Renflexis		•	

PLEASE PROCEED TO PAGE 2 FOR DIAGNOSES

Simponi/Simponi Aria, Skyrizi, Sotyktu, Spevigo, Stelara, Taltz, Tremfya, Truxima, Xeljanz/Xeljanz XR, Zymfentra.

PAGE 1 of 8



Federal Employee Program.

ADALIMUMAB PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to: Service Benefit Plan **Prior Approval** P.O. Box 52080 MC 139 Phoenix, AZ 85072-2080 **Attn. Clinical Services** Fax: 1-877-378-4727

		IAN COMPLETES	
Patient Name:	DOB:	Patient ID: I	R
8. What is the patient's d	liagnosis?		
☐ Ankylosing spondy	litis (AS)		
a. Does the patien	nt have active ankylosing spondylitis (A	S)? □Yes □No	
	nt have an intolerance or contraindicatio nti-inflammatory drugs (NSAIDs)?		uate treatment response to at least two
c. Does the prescr	riber agree not to exceed the FDA labele	ed maintenance dose of 40mg	g every other week? □Yes □No
requested as a c	ic Option patient, for claims adjudicate change from one of the following to allo poni, or Xeljanz/Xeljanz XR? \(\square\)Yes*	w the member access to their	
*If YES, sele	ect medication: Bimzelx Cimzia	□Cosentyx □Simponi	□Xeljanz/Xeljanz XR
☐ Crohn's disease (CI	D)		
a. Does the patien	nt have moderately to severely active Cr	ohn's disease (CD)? □Yes	□No
	nt have an intolerance or contraindication derapy option? □Yes □No	n or have they had an inadeq	uate treatment response to at least one
requested as a c □Yes* □! d. Age 6-17 : Wha	c Option patient, for claims adjudicate change from Cimzia, Entyvio, Omvoh, on *If YES, please select medication at is the patient's weight? Please select to	or Zymfentra to allow the me : □Cimzia □Entyvio	mber access to their copay benefit?
☐Less than 17	(kg (37lbs)		
	to less than 40kg (88lbs): Does the preother week? □Yes □No	escriber agree not to exceed t	he FDA labeled maintenance dose of
	n or equal to 40kg (88lbs): Does the prother week? □Yes □No	escriber agree not to exceed to	the FDA labeled maintenance dose of
e. Age 18 or olde week? □Yes	er: Does the prescriber agree not to exce ☐No	ed the FDA labeled maintena	ance dose of 40mg every other
☐ Hidradenitis suppur	rativa (HS)		
a. Age 12-17 : Wh	nat is the patient's weight? Please select	answer below:	
☐Less than 30	0kg (66lbs)		
	to less than 60kg (132lbs): Does the pother week? \Box Yes \Box No	rescriber agree not to exceed	the FDA labeled maintenance dose of
☐Greater than	n or equal to 60kg (132lbs): Which dos	sing is being requested? Plea	se select answer below:
□40mg: D	Ooes the prescriber agree not to exceed the	he FDA labeled maintenance	dose of 40mg every week? □Yes □
□80mg: De	oes the prescriber agree not to exceed the	FDA labeled maintenance dos	e of 80mg every other week? □Yes □
b. Age 18 or olde	er: Which dosing is being requested? Pla	ease select answer below:	
_	es the prescriber agree not to exceed the		ose of 40mg every week? □Yes □
□80mg: Does	s the prescriber agree not to exceed the FI	DA labeled maintenance dose	of 80mg every other week? □Yes □

PLEASE PROCEED TO PAGE 3 FOR ADDITIONAL DIAGNOSES

PAGE 2 of 8



ADALIMUMAB

DACE 2 DIIVCICIAN COMDITEES

Service Benefit Plan **Prior Approval** Federal Employee Program. PRIOR APPROVAL REQUEST

P.O. Box 52080 MC 139 Phoenix, AZ 85072-2080 **Attn. Clinical Services** Fax: 1-877-378-4727

Send completed form to:

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

	PAGE 3 - PHYSICIAL	NCOMPLETES	
Patient Name:	DOB:	Patient ID: R	
☐ Plaque psoriasis (PsO)			
• •	onic moderate to severe plaque p	soriasis (PsO)?	
b. Does the patient have an is systemic therapy? <i>Please so</i>		r have they had an inadequate tr	eatment response to conventional
	☐Intolerance or contraindicati	on Has not tried conventio	nal systemic therapy
			eatment response to phototherapy
•	☐ Intolerance or contraindicati	•	
	not to exceed the FDA labeled n	<u> -</u>	± •
	following to allow the member a		this medication being requested a nzelx, Cimzia, Cosentyx, Ilumya
*If YES, select medicati	ion: □Bimzelx □Cimzia □	□Cosentyx □Ilumya □Sil	iq □Sotyktu
☐ Polyarticular juvenile idiopath	ic arthritis (pJIA)		
a. Does the patient have mod	derately to severely active polyar	ticular course juvenile idiopath	ic arthritis (pJIA)? □Yes □N
	ntolerance or contraindication or ational disease-modifying antirhe		
	patient, <u>for claims adjudicated</u> ge from Actemra SC, Cimzia, or ☐No		
*If YES, please select m	nedication: Actemra SC O	Cimzia Orencia SC	
d. Age 2-17 : What is the patr	ient's weight? Please select ans	wer below:	
☐Less than 10kg (22lbs)	•		
□10kg (22lbs) to less tha 10mg every other week?	in 15kg (33lbs): Does the prescr? □Yes □No	iber agree not to exceed the FD	A labeled maintenance dose of
□15kg (33lbs) to less that 20mg every other week?	in 30kg (66lbs): Does the prescr? □Yes □No	iber agree not to exceed the FD	A labeled maintenance dose of
□Greater than or equal 40mg every other week	to 30kg (66lbs): Does the prescr ? □Yes □No	riber agree not to exceed the FD	A labeled maintenance dose of
e. Age 18 or older : Does the week? □Yes □No	e prescriber agree not to exceed t	the FDA labeled maintenance de	ose of 40mg every other
☐ Psoriatic arthritis (PsA)			
a. Does the patient have active	ve psoriatic arthritis (PsA)?	'es □No	
b. Does the patient have an intrial of at least one conven	ntolerance or contraindication on tional DMARD? □Yes □No	•	eatment response to a 3-month
c. Does the prescriber agree	not to exceed the FDA labeled n	naintenance dose of 40mg every	other week? □Yes □No
requested as a change fron	patient, for claims adjudicated in one of the following to allow the Simponi? $\square Yes^* \square No$		
	nedication: □Bimzelx □Cimz	tia □Cosentyx □Orencia S	SC □Simponi

PLEASE PROCEED TO PAGE 4 FOR ADDITIONAL DIAGNOSES

PAGE 3 of 8



ADALIMUMAB PRIOR APPROVAL REQUEST

Send completed form to: Service Benefit Plan **Prior Approval** P.O. Box 52080 MC 139 Phoenix, AZ 85072-2080

Attn. Clinical Services Fax: 1-877-378-4727

PAGE 4 of 8

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Name:	DOB:	Patient ID: R
☐ Rheumatoid arthritis (RA)		
a. Does the patient have m	moderate to severely active rheumate	oid arthritis (RA)? □Yes □No
		have they had an inadequate treatment response to a 3 month umatic drug (DMARD)? □Yes □No
requested as a change fr Actemra SC biosimilar,		through the pharmacy benefit: Is this medication being the member access to their copay benefit: Actemra SC or an int, Orencia SC, or Simponi?
□Actemra SC/Actem	nra SC biosimilar □Cimzia □F	Kevzara □Kineret □Olumiant □Orencia SC □Simponi
_		otrexate (MTX)? Please select answer below:
•	•	beled maintenance dose of 40mg every other week? □Yes □No
•	being requested? Please select answ	
_	•	DA labeled maintenance dose of 40mg every week? \(\sigma\)Yes \(\sigma\)No
	he prescriber agree not to exceed the \(\subseteq \text{Yes} \) \(\subseteq \text{No} \)	e FDA labeled maintenance dose of 80mg every other
☐ Ulcerative colitis (UC)		
 a. Does the patient have an conventional therapy op 		have they had an inadequate treatment response to at least one
requested as a change fr		through the pharmacy benefit: Is this medication being the member access to their copay benefit: Entyvio, Omvoh, atra? \(\sigma\)Yes* \(\sigma\)No
*If YES, please select m	medication: □Entyvio □Omvoh □Zeposia □Zymfent	□Simponi □Velsipity □Xeljanz/Xeljanz XR tra
c. Age 5-17 : What is the p	patient's weight? Please select answ	ver below:
□Less than 20kg (44lb	bs)	
□20kg (44lbs) to less the	than 40kg (88lbs): Which dosing is	s being requested? Please select answer below:
□40mg: Does the p		FDA labeled maintenance dose of 20mg every week? □Yes □No FDA labeled maintenance dose of 40mg every other
☐Greater than or equa	ual to 40kg (88lbs): Which dosing i	s being requested? Please select answer below:
□80mg: Does the p		FDA labeled maintenance dose of 40mg every week? □Yes □No FDA labeled maintenance dose of 80mg every other
- C	the patient a pediatric patient who he dosage? <i>Please select answer belo</i>	as since turned 18 years of age and is well controlled on the w:
□Yes: Which dosing is	s being requested? Please select stre	ength and answer the following question: FDA labeled maintenance dose of 20mg every week? □Yes □No
_	•	FDA labeled maintenance dose of 40mg every week? \(\sigma\)Yes \(\sigma\)No
□80mg: Does th		ne FDA labeled maintenance dose of 80mg every other
		beled maintenance dose of 40mg every other week? The Solution Yes
•	•	OR ADDITIONAL DIAGNOSES



ADALIMUMAB Federal Employee Program. PRIOR APPROVAL REQUEST

Send completed form to: Service Benefit Plan **Prior Approval** P.O. Box 52080 MC 139 Phoenix, AZ 85072-2080 **Attn. Clinical Services**

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

ysician portion and submit this completed form.		Fax: 1-877-378-4727
	PAGE 5 - PHYSICIAN	COMPLETES
Patient Name:	DOB:	Patient ID: R
☐Uveitis		
a. Age 2-17: What is the	patient's weight? Please select answ	er below:
☐Less than 10kg (22l	bs)	
□10kg (22lbs) to less 10mg every other we		per agree not to exceed the FDA labeled maintenance dose of
□15kg (33lbs) to less 20mg every other we		per agree not to exceed the FDA labeled maintenance dose of
□Greater than or equal 40mg every other was		ber agree not to exceed the FDA labeled maintenance dose of
b. Age 18 or older : Does week? □Yes □No	the prescriber agree not to exceed the	ne FDA labeled maintenance dose of 40mg every other
☐ Other (please specify):		

PAGE 5 of 8



Federal Employee Program.

ADALIMUMAB PRIOR APPROVAL REQUEST

Send completed form to: Service Benefit Plan Prior Approval P.O. Box 52080 MC 139 Phoenix, AZ 85072-2080 Attn. Clinical Services

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Date: Patient Name: Specialty: Specialty: Specialty: State: Specialty: Office Phone: Office Fax: Office Fax: Office Phone: Office Fax: Office Fax: Office Street Address: Office Street Address: Office Street Address: Office Street Address: Office Fax: Office Street Address: Office Street Address: Office Fax: Office Fax: Office Street Address: Office Fax: Office Fax: Office Street Address: Office Fax: Offic		Patient Inform	nation (required)		Pro	ovider Informatio	n (required)	
Date of Birth: Sex: Male					_			
City: State: Zip: City: State: Zip: Physician Signature:	Patient Name:				Specialty:	y: NPI:		
Patient ID: Physician Signature: Physic	Date of Birth:		Sex: □Male	□Female	Office Phone:	Office	Fax:	
Physician Signature: Physician Signature: Physician Signature:	Street Address:				Office Street Address	SS:		
CONTINUATION OF THERAPY (PA RENEWAL) NOTE: Form must be completed in its entirety for processing Please select medication: Darilada (adalimumab)	City:		State:	Zip:	City:	State:	Zip:	
CONTINUATION OF THERAPY (PA RENEWAL) NOTE: Form must be completed in its entirety for processing Please select medication: Abrilada (adalimumab)	Patient ID:				Physician Signature:	<u> </u>		
CONTINUATION OF THERAPY (PA RENEWAL) NOTE: Form must be completed in its entirety for processing Please select medication: Abrilada (adalimumab)	K	<u> </u>	<u> </u>	PHYSICIAN	COMPLETES			
Amjevita (adalimumab-atto)	Please select m				•	ŕ		
1. Has the patient been on this medication continuously for the last 6 months, excluding samples? Please select answer below: □NO − this is INITIATION of therapy, please answer the questions on PAGE 1 □YES − this is a PA renewal for CONTINUATION of therapy, please answer the questions below: 2. Is this request for brand or generic? □Brand □Generic 3. Has the patient's condition improved or stabilized with therapy? □Yes □No 4. Does the patient have any active infections including tuberculosis (TB) or hepatitis B virus (HBV)? □Yes □No 5. Will the patient be given live vaccines while on this therapy? □Yes □No 6. Will this medication be used in combination with another biologic *DMARD or targeted synthetic DMARD? □Yes* □No *If YES, please specify medication: *DMARDs: Actenra or an Actenra biosimilar, Avsola, Bimzelx, Cimzia, Cosentyx, Enbrel, Entyvio, Humira or a Humira biosimilal Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Riabni, Rinvoq, Rituxan, Ruxience, Siliq, Simponi/Simponi Aria, Skyrizi, Sotyktu, Spevigo, Stelara, Taltz, Tremfya, Truxima, Xeljanz/Xeljanz XR, Zymfentra. 7. What is the patient's diagnosis? □Ankylosing spondylitis (AS) a. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? □Yes □No □Crohn's disease (CD) a. Age 6-17: What is the patient's weight? Please select answer below: □Less than 17kg (37lbs) to less than 40kg (88lbs): Does the prescriber agree not to exceed the FDA labeled maintenance dose of	□Amjevita (a □Cyltezo (ad	dalimumab-atto) alimumab-adbm)	□Huı □Hyı	mira (adalimu rimoz □(adal	mab) imumab-adaz)	□Yuflyma (adalin	numab-aaty)	
□NO – this is INITIATION of therapy, please answer the questions on PAGE 1 □YES – this is a PA renewal for CONTINUATION of therapy, please answer the questions below: 2. Is this request for brand or generic? □Brand □Generic 3. Has the patient's condition improved or stabilized with therapy? □Yes □No 4. Does the patient have any active infections including tuberculosis (TB) or hepatitis B virus (HBV)? □Yes □No 5. Will the patient be given live vaccines while on this therapy? □Yes □No 6. Will this medication be used in combination with another biologic *DMARD or targeted synthetic DMARD? □Yes* □No *If YES, please specify medication: *DMARDs: Actemra or an Actemra biosimilar, Avsola, Bimzelx, Cimzia, Cosentyx, Enbrel, Entyvio, Humira or a Humira biosimil Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Riabni, Rinvoq, Rituxan, Ruxience, Siliq, Simponi/Simponi Aria, Skyrizi, Sotyktu, Spevigo, Stelara, Taltz, Tremfya, Truxima, Xeljanz/Xeljanz XR, Zymfentra. 7. What is the patient's diagnosis? □Ankylosing spondylitis (AS) a. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? □Yes □No □Crohn's disease (CD) a. Age 6-17: What is the patient's weight? Please select answer below: □Less than 17kg (37lbs) □No □17kg (37lbs) to less than 40kg (88lbs): Does the prescriber agree not to exceed the FDA labeled maintenance dose of the FDA labeled maintena	**Check www.fep	blue.org/formulary to	confirm which medic	cation is part of th	e patient's benefit			
Simponi/Simponi Aria, Skyrizi, Sotyktu, Spevigo, Stelara, Taltz, Tremfya, Truxima, Xeljanz/Xeljanz XR, Zymfentra. 7. What is the patient's diagnosis? □Ankylosing spondylitis (AS) a. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? □Yes □No □Crohn's disease (CD) a. Age 6-17: What is the patient's weight? Please select answer below: □Less than 17kg (37lbs) □17kg (37lbs) to less than 40kg (88lbs): Does the prescriber agree not to exceed the FDA labeled maintenance dose of	■ NO – this ■ YES – thi 2. Is this reques 3. Has the patie 4. Does the patie 5. Will the patie 6. Will this mee *If YES, p	is INITIATION of s is a PA renewal fact for brand or generative condition implient have any active ent be given live vertication be used in please specify med RDs: Actemra or an	of therapy, please for CONTINUAT eric? □Brand □ crowed or stabilized re infections include accines while on the combination with ication: □ Actemra biosimilar.	answer the que TION of therapy ☐Generic d with therapy? ding tuberculosi his therapy? ☐ another biolog	stions on PAGE 1 y, please answer the of PAGE 1 x, Cimzia, Cosentyx, E	questions below: s virus (HBV)? Yes eted synthetic DMARI anbrel, Entyvio, Humira of	□No O? □Yes* □No or a Humira biosimilar,	
 a. Age 6-17: What is the patient's weight? Please select answer below: □ Less than 17kg (37lbs) □ 17kg (37lbs) to less than 40kg (88lbs): Does the prescriber agree not to exceed the FDA labeled maintenance dose of 	Ilumya, Simpon 7. What is the p □Ankylosin	Inflectra, Kevzara, i/Simponi Aria, Sky patient's diagnosis' g spondylitis (AS)	Kineret, Olumiant, rizi, Sotyktu, Spevig ?	Orencia, Otezla, go, Stelara, Taltz	, Remicade, Renflexis, , Tremfya, Truxima, X	Riabni, Rinvoq, Rituxan eljanz/Xeljanz XR, Zymf	n, Ruxience, Siliq, Gentra.	
	□Crohn's d a. Age 6 □Les	isease (CD) 5-17: What is the p is than 17kg (37lb	atient's weight? P	lease select ans	swer below:			
20mg every other week? □Yes □No □Greater than or equal to 40kg (88lbs): Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? □Yes □No b. Age 18 or older: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other	20n □ Gr e 40n	ng every other wee eater than or equang every other wee	ek? □Yes □No al to 40kg (88lbs) ek? □Yes □No	: Does the preso	criber agree not to ex	ceed the FDA labeled	maintenance dose of	

PLEASE PROCEED TO PAGE 7 FOR ADDITIONAL DIAGNOSES

PAGE 6 of 8



ADALIMUMAB

Service Benefit Plan **Prior Approval** P.O. Box 52080 MC 139 Federal Employee Program. PRIOR APPROVAL REQUEST

Phoenix, AZ 85072-2080 **Attn. Clinical Services** Fax: 1-877-378-4727

Send completed form to:

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

	PAGE 7 - PHYSICIA	N COMPLETES
Patient Name:	DOB:	Patient ID: R
☐Hidradenitis suppurativa (HS)		
a. Age 12-17: What is the patient's	s weight? Please select an	swer below:
□Less than 30kg (66lbs)		
□30kg (66lbs) to less than 60k 40mg every other week? □Y		criber agree not to exceed the FDA labeled maintenance dose of
☐Greater than or equal to 60l	kg (132lbs): Which dosing	g is being requested? Please select answer below:
□40mg: Does the prescribe	er agree not to exceed the	FDA labeled maintenance dose of 40mg every week? □Yes □No
□80mg: Does the prescriber	agree not to exceed the FD	A labeled maintenance dose of 80mg every other week? □Yes □No
b. Age 18 or older: Which dosing	is being requested? Pleas	e select answer below:
□40mg: Does the prescriber ag	ree not to exceed the FDA	labeled maintenance dose of 40mg every week? □Yes □No
□80mg: Does the prescriber agre	e not to exceed the FDA la	beled maintenance dose of 80mg every other week? □Yes □No
□Plaque psoriasis (PsO)		
a. Does the prescriber agree not to	exceed the FDA labeled i	maintenance dose of 40mg every other week? □Yes □No
☐Polyarticular juvenile idiopathic arth	nritis (pJIA)	
a. Age 2-17: What is the patient's	weight? Please select ans	wer below:
☐Less than 10kg (22lbs)		
□10kg (22lbs) to less than 15k 10mg every other week? □Y		riber agree not to exceed the FDA labeled maintenance dose of
□15kg (33lbs) to less than 30k 20mg every other week? □Y		riber agree not to exceed the FDA labeled maintenance dose of
□Greater than or equal to 30l 40mg every other week? □Y		riber agree not to exceed the FDA labeled maintenance dose of
b. Age 18 or older : Does the prese week? \square Yes \square No	criber agree not to exceed	the FDA labeled maintenance dose of 40mg every other
☐Psoriatic arthritis (PsA)		
a. Does the prescriber agree not to	exceed the FDA labeled a	maintenance dose of 40mg every other week? □Yes □No
□Rheumatoid arthritis (RA)		
a. Will the patient be receiving con	ncurrent therapy with metl	hotrexate (MTX)? Please select answer below:
☐Yes: Does the prescriber agre	e not to exceed the FDA la	abeled maintenance dose of 40mg every other week? □Yes □No
□ No : Which dosing is being red	quested? <i>Please select ans</i>	swer below:
□40mg: Does the prescrib	per agree not to exceed the I	FDA labeled maintenance dose of 40mg every week? □Yes □No
□80mg: Does the prescr week? □Yes		ne FDA labeled maintenance dose of 80mg every other

PLEASE PROCEED TO PAGE 8 FOR ADDITIONAL DIAGNOSES

PAGE 7 of 8



ADALIMUMAB PRIOR APPROVAL REQUEST

Service Benefit Plan Prior Approval P.O. Box 52080 MC 139 Phoenix, AZ 85072-2080

Phoenix, AZ 85072-2080 Attn. Clinical Services Fax: 1-877-378-4727

Send completed form to:

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

	PAGE 8 - PHYSICIAN	COMPLETES	
Patient Name:	DOB:	Patient ID: R	
□Ulcerative colitis (UC) a. Age 5-17: What is the patie □Less than 20kg (44lbs)	ent's weight? <i>Please select answ</i>	er below:	
0 , ,		being requested? <i>Please select answer below:</i> DA labeled maintenance dose of 20mg every week? Yes	□No
□40mg: Does the presc	riber agree not to exceed the FDA	labeled maintenance dose of 40mg every other week? \square Yes	□No
☐Greater than or equal t	o 40kg (88lbs): Which dosing is	being requested? Please select answer below:	
□40mg: Does the pres	scriber agree not to exceed the F	DA labeled maintenance dose of 40mg every week? Tyes	□No
□80mg: Does the presc	riber agree not to exceed the FDA	labeled maintenance dose of 80mg every other week? \square Yes	□No
	patient a pediatric patient who has age? <i>Please select answer below</i>	as since turned 18 years of age and is well controlled on the v:	;
☐Yes: Which dosing is bei	ng requested? Please select stren	ngth and answer the following question:	
□20mg: Does the pr	rescriber agree not to exceed the F	DA labeled maintenance dose of 20mg every week? \(\sigma\)Yes	□No
□40mg: Does the pr	rescriber agree not to exceed the F	DA labeled maintenance dose of 40mg every week? □Yes	□No
	prescriber agree not to exceed the Yes \text{No}	e FDA labeled maintenance dose of 80mg every other	
□ No : Does the prescriber a	agree not to exceed the FDA labe	eled maintenance dose of 40mg every other week? Tyes	□No
□Uveitis			
a. Age 2-17: What is the patie	ent's weight? Please select answ	er below:	
□Less than 10kg (22lbs)			
□10kg (22lbs) to less than 10mg every other week?		per agree not to exceed the FDA labeled maintenance dose	of
□15kg (33lbs) to less than 20mg every other week?		per agree not to exceed the FDA labeled maintenance dose	of
☐Greater than or equal to 40mg every other week?		ber agree not to exceed the FDA labeled maintenance dose	of
b. Age 18 or older : Does the week? □Yes □No	prescriber agree not to exceed the	ne FDA labeled maintenance dose of 40mg every other	
☐Other (please specify):			

PAGE 8 of 8