BlueCross BlueShield 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

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:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

NOTE: Form must be completed in its **entirety** for processing

Please select medication:

❑**Abrilada (adalimumab)**	❑**Hulio** ❑**(adalimumab-fkjp)**	❑**Simlandi (adalimumab-ryvk)**
❑**Amjevita (adalimumab-atto)**	❑**Humira (adalimumab)**	❑**Yuflyma (adalimumab-aaty)**
❑**Cyltezo (adalimumab-adbm)**	❑**Hyrimoz** ❑**(adalimumab-adaz)**	❑**Yusimry (adalimumab-aqvh)**
❑**Hadlima (adalimumab-bwwd)**	❑**Idacio (adalimumab-aacf)**	

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

1. Has the patient been on this medication continuously for the last **6 months** excluding samples? ***Please select answer below:***
   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions on **PAGE 6**
   ❑**NO** – this is **INITIATION** of therapy, please answer the questions below:

2. Is this request for brand or generic? ❑Brand ❑Generic

3. Has the patient been tested for latent tuberculosis (TB)? ❑Yes* ❑No
   If YES, was the result of the test positive or negative for TB infection? ❑Positive* ❑Negative
   If POSITIVE, has the patient completed treatment or is the patient currently receiving treatment for latent TB? ❑Yes ❑No

4. Is the patient at risk for hepatitis B virus (HBV) infection? ❑Yes* ❑No
   If YES, has hepatitis B virus (HBV) infection been ruled out or has the patient already started treatment for HBV infection? ❑Yes ❑No

5. Does the patient have any active infections including tuberculosis (TB) or hepatitis B virus (HBV)? ❑Yes ❑No

6. Will the patient be given live vaccines while on this therapy? ❑Yes ❑No

7. Will this medication be used in combination with another biologic *DMARD or targeted synthetic DMARD? ❑Yes* ❑No
   If YES, please specify the medication: _____
   DMARDs: Actemra or an Actemra biosimilar, Avsola, Bimzelx, Cimzia, Cosentyx, Enbrel, Entyvio, Humira or a Humira biosimilar, 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.

PLEASE PROCEED TO PAGE 2 FOR DIAGNOSES

BlueCross BlueShield Federal Employee Program

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PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

8. What is the patient's diagnosis?

❑ Ankylosing spondylitis (AS)

a. Does the patient have active ankylosing spondylitis (AS)? ❑Yes ❑No

b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least two non-steroidal anti-inflammatory drugs (NSAIDs)? ❑Yes ❑No

c. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

d. **Standard/Basic Option patient, <u>for claims adjudicated through the pharmacy benefit</u>:** Is this medication being requested as a change from one of the following to allow the member access to their copay benefit: Bimzelx, Cimzia, Cosentyx, Simponi, or Xeljanz/Xeljanz XR? ❑Yes* ❑No

If YES, select medication: ❑Bimzelx ❑Cimzia ❑Cosentyx ❑Simponi ❑Xeljanz/Xeljanz XR

❑ Crohn's disease (CD)

a. Does the patient have moderately to severely active Crohn's disease (CD)? ❑Yes ❑No

b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least one conventional therapy option? ❑Yes ❑No

c. **Standard/Basic Option patient, <u>for claims adjudicated through the pharmacy benefit</u>:** Is this medication being requested as a change from Cimzia, Entyvio, Omvoh, or Zymfentra to allow the member access to their copay benefit?
❑Yes* ❑No ***If YES***, please select medication: ❑Cimzia ❑Entyvio ❑Omvoh ❑Zymfentra

d. **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 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

e. **Age 18 or older**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

❑ Hidradenitis suppurativa (HS)

a. **Age 12-17**: What is the patient's weight? ***Please select answer below:***

❑Less than 30kg (66lbs)

❑30kg (66lbs) to less than 60kg (132lbs): Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

❑Greater than or equal to 60kg (132lbs): Which dosing is being requested? ***Please select answer below:***

❑40mg: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every week? ❑Yes ❑No

❑80mg: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 80mg every other week? ❑Yes ❑No

b. **Age 18 or older**: Which dosing is being requested? ***Please select answer below:***

❑40mg: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every week? ❑Yes ❑No

❑80mg: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 80mg every other week? ❑Yes ❑No

PLEASE PROCEED TO <u>PAGE 3</u> FOR ADDITIONAL DIAGNOSES

BlueCross BlueShield Federal Employee Program

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PAGE 3 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

❑ Plaque psoriasis (PsO)

a. Does the patient have chronic moderate to severe plaque psoriasis (PsO)? ❑Yes ❑No

b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to conventional systemic therapy? ***Please select answer below:***

❑Inadequate response ❑Intolerance or contraindication ❑Has not tried conventional systemic therapy

c. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to phototherapy?

❑Inadequate response ❑Intolerance or contraindication ❑Has not tried phototherapy

d. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

e. **Standard/Basic Option patient, <u>for claims adjudicated through the pharmacy benefit</u>:** Is this medication being requested as a change from one of the following to allow the member access to their copay benefit: Bimzelx, Cimzia, Cosentyx, Ilumya, Siliq, or Sotyktu? ❑Yes***** ❑No

****If YES***, select medication: ❑Bimzelx ❑Cimzia ❑Cosentyx ❑Ilumya ❑Siliq ❑Sotyktu

❑ Polyarticular juvenile idiopathic arthritis (pJIA)

a. Does the patient have moderately to severely active polyarticular course juvenile idiopathic arthritis (pJIA)? ❑Yes ❑No

b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a 3-month trial of at least one conventional disease-modifying antirheumatic drug (DMARD)? ❑Yes ❑No

c. **Standard/Basic Option patient, <u>for claims adjudicated through the pharmacy benefit</u>:** Is this medication being requested as a change from Actemra SC, Cimzia, or Orencia SC to allow the member access to their copay benefit? ❑Yes***** ❑No

****If YES***, please select medication: ❑Actemra SC ❑Cimzia ❑Orencia SC

d. **Age 2-17**: What is the patient's weight? ***Please select answer below:***

❑Less than 10kg (22lbs)

❑10kg (22lbs) to less than 15kg (33lbs): Does the prescriber agree not to exceed the FDA labeled maintenance dose of 10mg every other week? ❑Yes ❑No

❑15kg (33lbs) to less than 30kg (66lbs): Does the prescriber agree not to exceed the FDA labeled maintenance dose of 20mg every other week? ❑Yes ❑No

❑Greater than or equal to 30kg (66lbs): Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

e. **Age 18 or older**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

❑ Psoriatic arthritis (PsA)

a. Does the patient have active psoriatic arthritis (PsA)? ❑Yes ❑No

b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a 3-month trial of at least one conventional DMARD? ❑Yes ❑No

c. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

d. **Standard/Basic Option patient, <u>for claims adjudicated through the pharmacy benefit</u>:** Is this medication being requested as a change from one of the following to allow the member access to their copay benefit: Bimzelx, Cimzia, Cosentyx, Orencia SC, or Simponi? ❑Yes***** ❑No

****If YES***, please select medication: ❑Bimzelx ❑Cimzia ❑Cosentyx ❑Orencia SC ❑Simponi

PLEASE PROCEED TO <u>PAGE 4</u> FOR ADDITIONAL DIAGNOSES

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

PAGE 4 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

❑ Rheumatoid arthritis (RA)

a. Does the patient have moderate to severely active rheumatoid arthritis (RA)? ❑Yes ❑No

b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a 3 month trial of at least one conventional disease modifying antirheumatic drug (DMARD)? ❑Yes ❑No

c. **Standard/Basic Option patient, <u>for claims adjudicated through the pharmacy benefit</u>:** Is this medication being requested as a change from one of the following to allow the member access to their copay benefit: Actemra SC or an Actemra SC biosimilar, Cimzia, Kevzara, Kineret, Olumiant, Orencia SC, or Simponi?
❑Yes***** ***(*If YES, please select medication below)*** ❑No

❑Actemra SC/Actemra SC biosimilar ❑Cimzia ❑Kevzara ❑Kineret ❑Olumiant ❑Orencia SC ❑Simponi

d. Will the patient be receiving concurrent therapy with methotrexate (MTX)? ***Please select answer below:***

❑**Yes**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

❑**No**: Which dosing is being requested? ***Please select answer below:***

❑**40mg:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every week? ❑Yes ❑No

❑**80mg:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 80mg every other week? ❑Yes ❑No

❑ Ulcerative colitis (UC)

a. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least one conventional therapy option? ❑Yes ❑No

b. **Standard/Basic Option patient, <u>for claims adjudicated through the pharmacy benefit</u>:** Is this medication being requested as a change from one of the following to allow the member access to their copay benefit: Entyvio, Omvoh, Simponi, Velsipity, Xeljanz/Xeljanz XR, Zeposia, Zymfentra? ❑Yes***** ❑No

****If YES***, please select medication: ❑Entyvio ❑Omvoh ❑Simponi ❑Velsipity ❑Xeljanz/Xeljanz XR ❑Zeposia ❑Zymfentra

c. **Age 5-17**: What is the patient's weight? ***Please select answer below:***

❑**Less than 20kg (44lbs)**

❑**20kg (44lbs) to less than 40kg (88lbs)**: Which dosing is being requested? ***Please select answer below:***

❑**20mg:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 20mg every week? ❑Yes ❑No

❑**40mg:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

❑**Greater than or equal to 40kg (88lbs)**: Which dosing is being requested? ***Please select answer below:***

❑**40mg:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every week? ❑Yes ❑No

❑**80mg:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 80mg every other week? ❑Yes ❑No

d. **Age 18 or older**: Was the patient a pediatric patient who has since turned 18 years of age and is well controlled on the recommended pediatric dosage? ***Please select answer below:***

❑**Yes**: Which dosing is being requested? ***Please select strength and answer the following question:***

❑**20mg**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 20mg every week? ❑Yes ❑No

❑**40mg**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every week? ❑Yes ❑No

❑**80mg**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 80mg every other week? ❑Yes ❑No

❑**No**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

PLEASE PROCEED TO <u>PAGE 5</u> FOR ADDITIONAL DIAGNOSES

BlueCross BlueShield
Federal Employee Program

ADALIMUMAB
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PAGE 5 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

❑ Uveitis

a. **Age 2-17**: What is the patient's weight? ***Please select answer below:***

❑**Less than 10kg (22lbs)**

❑**10kg (22lbs) to less than 15kg (33lbs):** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 10mg every other week? ❑Yes ❑No

❑**15kg (33lbs) to less than 30kg (66lbs):** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 20mg every other week? ❑Yes ❑No

❑**Greater than or equal to 30kg (66lbs):** 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 week? ❑Yes ❑No

❑ Other ***(please specify)***: _____

BlueCross BlueShield Federal Employee Program

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

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:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

CONTINUATION OF THERAPY (PA RENEWAL)

NOTE: Form must be completed in its **entirety** for processing

Please select medication:

❑**Abrilada (adalimumab)**	❑**Hulio** ❑**(adalimumab-fkjp)**	❑**Simlandi (adalimumab-ryvk)**
❑**Amjevita (adalimumab-atto)**	❑**Humira (adalimumab)**	❑**Yuflyma (adalimumab-aaty)**
❑**Cyltezo (adalimumab-adbm)**	❑**Hyrimoz** ❑**(adalimumab-adaz)**	❑**Yusimry (adalimumab-aqvh)**
❑**Hadlima (adalimumab-bwwd)**	❑**Idacio (adalimumab-aacf)**	

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

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: Actemra or an Actemra biosimilar, Avsola, Bimzelx, Cimzia, Cosentyx, Enbrel, Entyvio, Humira or a Humira biosimilar, 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)**
   ❑**17kg (37lbs) to less than 40kg (88lbs)**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 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 week? ❑Yes ❑No

PLEASE PROCEED TO PAGE 7 FOR ADDITIONAL DIAGNOSES

BlueCross BlueShield Federal Employee Program

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PAGE 7 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

❑Hidradenitis suppurativa (HS)

a. **Age 12-17**: What is the patient's weight? ***Please select answer below:***

❑**Less than 30kg (66lbs)**

❑**30kg (66lbs) to less than 60kg (132lbs):** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

❑**Greater than or equal to 60kg (132lbs):** Which dosing is being requested? ***Please select answer below:***

❑**40mg:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every week? ❑Yes ❑No

❑**80mg:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 80mg every other week? ❑Yes ❑No

b. **Age 18 or older**: Which dosing is being requested? ***Please select answer below:***

❑**40mg:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every week? ❑Yes ❑No

❑**80mg:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 80mg every other week? ❑Yes ❑No

❑Plaque psoriasis (PsO)

a. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

❑Polyarticular juvenile idiopathic arthritis (pJIA)

a. **Age 2-17**: What is the patient's weight? ***Please select answer below:***

❑**Less than 10kg (22lbs)**

❑**10kg (22lbs) to less than 15kg (33lbs)**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 10mg every other week? ❑Yes ❑No

❑**15kg (33lbs) to less than 30kg (66lbs)**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 20mg every other week? ❑Yes ❑No

❑**Greater than or equal to 30kg (66lbs)**: 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 week? ❑Yes ❑No

❑Psoriatic arthritis (PsA)

a. Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

❑Rheumatoid arthritis (RA)

a. Will the patient be receiving concurrent therapy with methotrexate (MTX)? ***Please select answer below:***

❑**Yes**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

❑**No**: Which dosing is being requested? ***Please select answer below:***

❑**40mg:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every week? ❑Yes ❑No

❑**80mg:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 80mg every other week? ❑Yes ❑No

PLEASE PROCEED TO PAGE 8 FOR ADDITIONAL DIAGNOSES

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PAGE 8 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

❑Ulcerative colitis (UC)

a. **Age 5-17**: What is the patient's weight? ***Please select answer below:***

❑**Less than 20kg (44lbs)**

❑**20kg (44lbs) to less than 40kg (88lbs)**: Which dosing is being requested? ***Please select answer below:***

❑**20mg:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 20mg every week? ❑Yes ❑No

❑**40mg:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

❑**Greater than or equal to 40kg (88lbs)**: Which dosing is being requested? ***Please select answer below:***

❑**40mg:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every week? ❑Yes ❑No

❑**80mg:** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 80mg every other week? ❑Yes ❑No

b. **Age 18 or older**: Was the patient a pediatric patient who has since turned 18 years of age and is well controlled on the recommended pediatric dosage? ***Please select answer below:***

❑**Yes**: Which dosing is being requested? ***Please select strength and answer the following question:***

❑**20mg**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 20mg every week? ❑Yes ❑No

❑**40mg**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every week? ❑Yes ❑No

❑**80mg**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 80mg every other week? ❑Yes ❑No

❑**No**: Does the prescriber agree not to exceed the FDA labeled maintenance dose of 40mg every other week? ❑Yes ❑No

❑Uveitis

a. **Age 2-17**: What is the patient's weight? ***Please select answer below:***

❑**Less than 10kg (22lbs)**

❑**10kg (22lbs) to less than 15kg (33lbs):** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 10mg every other week? ❑Yes ❑No

❑**15kg (33lbs) to less than 30kg (66lbs):** Does the prescriber agree not to exceed the FDA labeled maintenance dose of 20mg every other week? ❑Yes ❑No

❑**Greater than or equal to 30kg (66lbs):** 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 week? ❑Yes ❑No

❑Other ***(please specify)***: _____