



Date _____

Client _____

PRIOR AUTH QUESTIONNAIRE - HUMIRA®

| | |
|-------------------------------|-----------------------------------|
| M.D. Last Name: _____ | M.D. First Name: _____ |
| Physician Phone: _____ | Physician Fax: _____ |
| Patient _____ | ID# _____ DOB _____ |

TO ENSURE PROMPT PROCESSING PLEASE COMPLETE ALL OF THE QUESTIONS.

TO AVOID UNNECESSARY DELAY, PLEASE SUBMIT A COPY OF THE PROGRESS NOTES, AND ALL OTHER NECESSARY SUPPORTING DOCUMENTATION ALONG WITH THIS PA FORM.

- Please indicate patient's diagnosis:
 - Rheumatoid Arthritis (RA)
 - Juvenile Idiopathic Arthritis-- Please also list the patient's weight: _____ Lbs.
 - Psoriatic Arthritis
 - Ankylosing spondylitis (AS)
 - Crohn's Disease
 - Plaque Psoriasis
 - Other* _____

**Note: If "Other" diagnosis is used, please attach a study with efficacy data supporting this request*
- Is the patient currently using methotrexate? **Yes** **No**
- For Crohn's Use Only- Please list first-line therapies that have been tried with an inadequate response,

- For Plaque Psoriasis Only- Please list the % of Body Surface Area with plaques: _____ %
- For Plaque Psoriasis Only- Please Circle if any of the following areas are involved: **HANDS** **FEET** **FACE** **GENITALS**
- Has the patient tested negative for latent TB? **Yes** **No**
- Strength Requested (Please Circle One): **40mg** **20mg**
- Quantity Requested: _____ SIG: _____

Physician Signature or name of person providing answers _____

Physician Comments _____

Send or Fax completed form to:
877-329-7279

RESTAT
11900 W. Lake Park Dr.
Milwaukee, WI 53224

QUESTIONS PLEASE CALL:
877-526-9906