



Date \_\_\_\_\_

Client \_\_\_\_\_

### PRIOR AUTH QUESTIONNAIRE - HUMIRA®

<b>M.D. Last Name:</b> _____	<b>M.D. First Name:</b> _____
<b>Physician Phone:</b> _____	<b>Physician Fax:</b> _____
<b>Patient</b> _____	<b>ID#</b> _____ <b>DOB</b> _____

**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  
P.O. BOX 758  
WEST BEND, WI 53095

QUESTIONS PLEASE CALL:  
**877-526-9906**