


TRICARE Prior Authorization Request Form for  
**Abrilada, Amjevita, Cyltezo, Hadlima, Hulio, Hyrimoz, Idacio, Simlandi,  
 Yuflyma, Yusimry**



6793

To be completed and signed by the prescriber.



**MARTIN'S POINT**<sup>®</sup>  
HEALTHCARE

**Clinical Documentation is required for  
a determination to be made.**

Please fax completed form back to: (207) 828-7816

Prior authorization does not expire.

**Step 1 Please complete patient and physician information** (please print):

<p><b>1</b> Patient Name: _____</p> <p>Address: _____</p> <p>Sponsor ID #: _____</p> <p>Date of Birth: _____</p>	<p>Physician Name: _____</p> <p>Address: _____</p> <p>Phone #: _____</p> <p>Secure Fax #: _____</p>
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**Step 2 Please complete the clinical assessment:**

<p>1. The originator Humira formulation is the preferred product over the biosimilar adalimumab formulations.</p>	<input type="checkbox"/> Acknowledged Proceed to question 2		
<p>2. Please provide a patient-specific justification as to why the originator Humira product cannot be used in this patient</p>	<hr style="width: 80%; margin: 0 auto;"/> Proceed to question 3		
<p>3. Is the patient 18 years of age or older?</p>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; text-align: center;"> <input type="checkbox"/> Yes proceed to question 11                             </td> <td style="width: 50%; text-align: center;"> <input type="checkbox"/> No proceed to question 4                             </td> </tr> </table>	<input type="checkbox"/> Yes proceed to question 11	<input type="checkbox"/> No proceed to question 4
<input type="checkbox"/> Yes proceed to question 11	<input type="checkbox"/> No proceed to question 4		
<p>4. What is the indication or diagnosis in this pediatric patient?</p> <p style="font-size: small;">Note: Non-FDA-approved uses are NOT approved, with the exception that if an indication is approved for Humira, it is approved for a biosimilar.</p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> moderate to severe active <b>polyarticular juvenile idiopathic arthritis (pJIA)</b> – proceed to question 5</li> <li><input type="checkbox"/> moderately to severely active <b>Crohn's disease</b> – proceed to question 7</li> <li><input type="checkbox"/> <b>Severe chronic plaque psoriasis</b> in patients who are candidates for systemic or phototherapy, and when other systemic therapies are medically less appropriate (4-17 years) – go to question 10</li> <li><input type="checkbox"/> moderately to severely active <b>ulcerative colitis</b> – go to question 6</li> <li><input type="checkbox"/> treatment of <b>uveitis</b> (non-infectious intermediate, posterior and panuveitis patients) – go to question 5</li> <li><input type="checkbox"/> <b>Hidradenitis suppurativa</b> – go to question 8</li> <li><input type="checkbox"/> Other indication or diagnosis – <b>STOP</b>: Coverage not approved.</li> </ul>		

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5. Is the patient 2 years of age or older?	<input type="checkbox"/> Yes proceed to question 15	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
6. Is the patient 5 years of age or older?	<input type="checkbox"/> Yes proceed to question 10	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
7. Is the patient 6 years of age or older?	<input type="checkbox"/> Yes proceed to question 9	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
8. Is the patient 12 years of age or older?	<input type="checkbox"/> Yes proceed to question 15	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
9. Does the patient have fistulizing CD?	<input type="checkbox"/> Yes proceed to question 15	<input type="checkbox"/> No proceed to question 10
10. Has the patient had an inadequate response to non-biologic systemic therapy? (For example: methotrexate, aminosalicylates [such as, sulfasalazine, mesalamine], corticosteroids, immunosuppressants [such as, azathioprine], etc.)?	<input type="checkbox"/> Yes proceed to question 15	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
11. What is the indication or diagnosis in this adult patient?  Note: Non-FDA-approved uses are NOT approved, with the exception that if an indication is approved for Humira, it is approved for a biosimilar.	<input type="checkbox"/> moderately to severely active <b>rheumatoid arthritis</b> – go to question 14 <input type="checkbox"/> active <b>psoriatic arthritis</b> – go to question 15 <input type="checkbox"/> <b>Ankylosing spondylitis</b> – go to question 12 <input type="checkbox"/> Active non-radiographic axial spondyloarthritis (nr-ax SpA) with objective signs of inflammation – go to question 14 <input type="checkbox"/> moderate to severe <b>chronic plaque psoriasis</b> in a patient who may benefit from taking injection or pills (systemic therapy) or phototherapy – go to question 14 <input type="checkbox"/> moderately to severely active <b>Crohn's disease</b> – go to question 13 <input type="checkbox"/> moderately to severely active <b>ulcerative colitis</b> – go to question 14 <input type="checkbox"/> moderately to severely active <b>pyoderma gangrenosum (PG)</b> that is refractory to high-potency corticosteroids– go to question 15 <input type="checkbox"/> treatment of <b>uveitis</b> (non-infectious intermediate, posterior and panuveitis patients) – go to question 15 <input type="checkbox"/> <b>Hidradenitis suppurativa</b> – go to question 15 <input type="checkbox"/> Other indication or diagnosis – <b>STOP: Coverage not approved.</b>	
12. Has the patient had an inadequate response to at least two NSAIDs over a period of at least two months?	<input type="checkbox"/> Yes proceed to question 15	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
13. Does the patient have fistulizing CD?	<input type="checkbox"/> Yes proceed to question 15	<input type="checkbox"/> No proceed to question 14
14. Has the patient had an inadequate response to non-biologic systemic therapy? (For example: methotrexate, aminosalicylates [such as, sulfasalazine, mesalamine], corticosteroids, immunosuppressants [such as, azathioprine], etc.)?	<input type="checkbox"/> Yes proceed to question 15	<input type="checkbox"/> No <b>STOP</b> Coverage not approved

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<b>15. Cases of worsening congestive heart failure (CHF) and new onset CHF have been reported with TNF blockers, including HUMIRA. Is the prescriber aware of this?</b>	<input type="checkbox"/> Yes proceed to question 16	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
<b>16. Has the patient had evidence of a negative TB test result in the past 12 months (or TB is adequately managed)?</b>	<input type="checkbox"/> Yes proceed to question 17	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
<b>17. Will the patient be receiving other targeted immunomodulatory biologics with Humira, including but not limited to the following: certolizumab (Cimzia), etanercept (Enbrel), golimumab (Simponi), infliximab (Remicade), apremilast (Otezla), ustekinumab (Stelara), abatacept (Orencia), anakinra (Kineret), tocilizumab (Actemra), tofacitinib (Xeljanz/Xeljanz XR), rituximab (Rituxan), secukinumab (Cosentyx), ixekizumab (Taltz), brodalumab (Siliq), sarilumab (Kevzara), guselkumab (Tremfya), baricitinib (Olumiant), tildrakizumab (Ilumya), risankizumab (Skyrizi), or upadacitinib (Rinvoq ER)?</b>	<input type="checkbox"/> Yes <b>STOP</b> Coverage not approved	<input type="checkbox"/> No <b>Sign and date below</b>

**Step 3** I certify the above is true to the best of my knowledge. Please sign and date:

\_\_\_\_\_  
 Prescriber Signature

\_\_\_\_\_  
 Date

[8 May 2024]