

# PEDIATRIC HUMIRA® ENROLLMENT FORM

Phone: **844-283-6308** • Fax: **844-965-9849**

## 1 PATIENT INFORMATION:

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Alt. Phone: \_\_\_\_\_  
 Email: \_\_\_\_\_  
 DOB: \_\_\_\_\_ Gender:  M  F Caregiver: \_\_\_\_\_  
 Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Allergies: \_\_\_\_\_

## 2 PRESCRIBER INFORMATION:

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 NPI: \_\_\_\_\_ DEA: \_\_\_\_\_  
 Tax I.D.: \_\_\_\_\_  
 Office Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

## 3 STATEMENT OF MEDICAL NECESSITY: (Please Attach All Medical Documentation)

Date of Diagnosis: \_\_\_\_\_ ICD-10: \_\_\_\_\_  
 Other: \_\_\_\_\_  
 TB Test:  Positive  Negative Date: \_\_\_\_\_  
 Serious or active infection present?  Yes  No  
 Hep B ruled out or treatment started?  Yes  No  
 Does patient have latex allergy?  Yes  No

### Prior Failed Treatments:

- 5-ASA
- Biologics
- Corticosteroids
- Immunosuppressants
- Methotrexate
- NSAIDS
- Surgery
- Topical/Oral Antibiotics
- UVA  UVB
- Others

### Indicate Drug Name and Length of Treatment:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**If Prior Authorization is denied, recommended formulary alternatives will be provided to the prescriber based upon the patient's insurance coverage.**

## 4 INJECTION TRAINING: Pharmacist to Provide Training Patient Trained in MD Office Manufacturer Nurse Support

## 5 PRODUCT DELIVERY: Patient's Home Physician's Office Pharmacy to Coordinate

## 6 INSURANCE INFORMATION: Please Include Front and Back Copies of Pharmacy and Medical Card

### PRESCRIPTION INFORMATION: (Please be sure to choose both induction and maintenance dose where applicable)

Patient Name: \_\_\_\_\_ Patient's Date of Birth: \_\_\_\_\_

Medication	Dosage & Strength	Direction	QTY Refills	
<input type="checkbox"/> HUMIRA®	<b>Hidradenitis Suppurativa</b>	<input type="checkbox"/> <b>Induction Dose:</b> <input type="checkbox"/> <b>Adolescents 12 years and older 66 lbs to &lt;132 lbs:</b> Inject 80mg SC on day 1, then 40mg SC on day 8 and every other week thereafter <input type="checkbox"/> <b>Adolescents 12 years and older &gt;132 lbs:</b> Inject two 80mg pens SC on day 1, then one 80mg pen SC on day 15 <input type="checkbox"/> <b>Adolescents 12 years and older &gt;132 lbs:</b> Inject one 80mg pen SC on day 1, then 80mg pen SC on day 2, then one 80mg pen SC on day 15 <input type="checkbox"/> <b>Maintenance Dose:</b> <input type="checkbox"/> <b>Adolescents 12 years and older 66 lbs to &lt;132 lbs:</b> Inject 40mg every other week <input type="checkbox"/> <b>Adolescents 12 years and older &gt;132 lbs:</b> Inject 40mg on day 29 then Inject 40mg every week	3	0
	<input type="checkbox"/> Adolescent Hidradenitis Suppurativa 80mg/0.8ml and 40mg/0.4ml Starter pack		4	0
	<input type="checkbox"/> Adolescent Hidradenitis Suppurativa 40mg/0.4ml Starter Package		3	0
	<input type="checkbox"/> Hidradenitis Suppurativa 80mg/0.8ml Starter pack <input type="checkbox"/> Hidradenitis Suppurativa 40mg/0.4ml Starter pack <input type="checkbox"/> 40mg/0.4ml Pen <input type="checkbox"/> 40mg/0.4ml Prefilled Syringe		6	0
<input type="checkbox"/> HUMIRA®	<b>Juvenile Idiopathic Arthritis + Pediatric Uveitis</b>	<input type="checkbox"/> <b>22 lbs to &lt;33 lbs:</b> Inject 10mg SC every other week <input type="checkbox"/> <b>33 lbs to &lt;66 lbs:</b> Inject 20mg SC every other week <input type="checkbox"/> <b>&gt;= 33 lbs:</b> Inject 40mg SC every other week	2	
	<input type="checkbox"/> 10mg/0.1ml Prefilled Syringe <input type="checkbox"/> 20mg/0.2ml Prefilled Syringe <input type="checkbox"/> 40mg/0.4ml Pen <input type="checkbox"/> 40mg/0.4ml Prefilled Syringe			
<input type="checkbox"/> HUMIRA®	<b>Pediatric Crohn's Disease</b>	<input type="checkbox"/> <b>Induction Dose:</b> <input type="checkbox"/> <b>37 lbs to &lt;88 lbs:</b> Inject one 80mg pen SC on day 1, then one 40mg pen SC on day 15 <input type="checkbox"/> <b>&gt;88 lbs:</b> Inject two 80mg pens SC on day 1, then one 80mg pen SC on day 15 <input type="checkbox"/> <b>&gt;88 lbs:</b> Inject one 80mg pen SC on day 1, then 80mg pen SC on day 2, then one 80mg pen SC on day 15 <input type="checkbox"/> <b>Maintenance Dose:</b> <input type="checkbox"/> <b>37 lbs to &lt;88 lbs:</b> Inject 20mg SC every other week <input type="checkbox"/> <b>&gt;88 lbs:</b> Inject 40mg SC every other week	2	0
	<input type="checkbox"/> Pediatric Crohn's Starter Pack: 80mg/0.8ml, 40mg/0.4ml		3	0
	<input type="checkbox"/> Pediatric Crohn's Starter Pack: 80mg/0.8ml			
	<input type="checkbox"/> 20mg/0.2ml Prefilled Syringe <input type="checkbox"/> 40mg/0.4ml Pen <input type="checkbox"/> 40mg/0.4ml Prefilled Syringe		2	
<i>All strengths and dosages listed are Humira® Citrate Free</i>				
<input type="checkbox"/>				

## PRESCRIBER SIGNATURE: I authorize pharmacy to act as my designee for initiating and coordinating insurance prior authorizations, nursing services and patient assistance programs.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Substitution Permitted**

**Dispense As Written**

Prior authorization approval and insurance benefits will be determined by the payor based upon the patient's eligibility, medical necessity, and the terms of the patient's coverage, among other things. Participation in this program is not a guarantee of prior authorization or of payment.

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