145 The West Mall, P.O. Box 110 U
Toronto, ON M8Z 5M4

PRIOR AUTHORIZATION PROGRAM FORM

Humira® (Adalimumab)

Instructions:

1. Section 1 to be completed by Plan Member/ Patient
2. Section 2 to be completed by Physician/ Pharmacist (expenses incurred by the completion of this form is at plan member's expense)
3. Section 3 to be completed by Pharmacist.

Please fax completed form to NexgenRx Formulary Management to 1-877-639-4369 or mail to 145 The West Mall P.O. Box 110 U, Toronto, Ontario, M8Z-5M4

Section 1: To be completed by Patient

Member's Name: (Last , First)	Card ID Number:																			
Patient's Name: (Last, First)	Patient's Date of Birth (dd/mm/yy)	Relationship to Member (please circle) Employee Spouse Dependent	PATIENT CODE		
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Results of this request to be communicated to:

☐ Pharmacy	☐ Patient / Legal Guardian Named Below	☐ email:

I authorize NexgenRx Inc. (a) to use the personal information disclosed on this form, and any other personal information known to NexgenRx Inc. regarding the above-named patient, for the purpose of assessing this prior authorization request and any related claim and administering the benefit plan under which any such claim is made, and (b) to contact, and to obtain any such personal information from and to disclose any such personal information to, any physician, pharmacist or other health care professional having knowledge of such patient's health relevant to this request and any related claim.

Patient / Legal Guardian Name: _____ Telephone Number: _____

Signature of Patient/ Legal Guardian: _____ Date (dd/mm/yy):_____

Section 2: To be completed by Physician/ Pharmacist

Drug Name & Strength:	DIN:	Dosage Instructions:

Eligibility for drug coverage is dependent upon the patient meeting at least one of the qualifying criteria listed below. If the patient has another drug plan, prior authorization may cover some or all of the excess not paid by the primary plan.

Please indicate if the patient meets at least one of the following qualifying criteria for drug coverage:

- ❑ To reduce the signs of moderate to severe active rheumatoid arthritis in adult patients.
- ❑ To reduce the signs and symptoms of moderate to severe active rheumatoid arthritis, in combination with DMARDs, in adults.
- ❑ To reduce the signs and symptoms of moderate to severe active polyarticular juvenile idiopathic arthritis in children aged 4-17
- ❑ To reduce the signs and symptoms of moderate to severe active Crohn's disease in adult patients and pediatric patients aged 13-17 weighing ≥ 40kg who have had an inadequate response to standard therapy and /or other TNF-blocker..
- ❑ To reduce the progression of structural damage of active arthritic disease in adult patients with psoriatic arthritis.
- ❑ To treat chronic moderate to severe plaque psoriasis in adults who are candidates for systemic therapy or phototherapy.
- ❑ To treat ankylosing spondylitis.
- ❑ To treat moderate to severe ulcerative colitis in adults who have shown inadequate or intolerant response to conventional therapy. Efficacy in patients who have lost response or are intolerant to other TNF- blockers has not been established.
- ❑ To treat active moderate to severe hidradenitis suppurativa in adult patients, who have not responded to conventional therapy (including systemic antibiotics).
- ❑ To treat non-infectious uveitis (intermediate, posterior and panuveitis) in adult patients with inadequate response to corticosteroids or as corticosteroid sparing treatment in corticosteroid-dependent patients.

Physician / Pharmacist Name: (Last, First)	License Number:
Address: (Street, City, Province, Postal Code)	Telephone Number : ( ) - Fax Number: ( ) -
Signature of Physician / Pharmacist:	Date (dd/mm/yy)

Section 3: To be completed by Pharmacist

Pharmacy Name:	Provider Number:
Pharmacy Address: (Street, City, Province, Postal Code)	Telephone Number : ( ) - Fax Number: ( ) -
Signature of Pharmacist: _____ Pharmacist's Name: (Print Last, First) _____	

Internal Office Use Only:

Date Received:			Date Approved: