



Prior Authorization Form Arthritis/Psoriasis Agents

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Enbrel® **Kineret®** **Humira®** **Amevive®** **Raptiva®**
 Quantity _____ Refill x _____ months
 Instructions _____
 Physician's signature _____ Provider NPI: _____ MD# _____
 Date: _____ Date medication needed _____

Patient Information

Patient's name _____
 Patient's address _____
 City, State, Zip: _____
 Patient's phone # _____
 Patient's ID#: _____ DOB _____

Prescriber Information

Prescribing physician _____
 Office address _____
 City, State, Zip: _____
 Office contact _____
 Office # _____ Fax# _____

Upon approval, delivery is available. Complete section below.

<input type="checkbox"/> No Delivery Requested	<input type="checkbox"/> Delivery Requested
<input type="checkbox"/> Physician Supply, authorization only [Flex series]	<input type="checkbox"/> Physician's office <input type="checkbox"/> Patient's home
<input type="checkbox"/> Member Pick up at pharmacy if benefit available	Preferred Vendor: _____

****A copy of the prescription must accompany the medication request****

- PHYSICIAN'S SPECIALTY (required)** Rheumatology Dermatology GI
 Other (specify all) _____
- DIAGNOSIS FOR DRUG REQUESTED**
 696.1 Chronic plaque psoriasis **696.0** Psoriatic arthritis **714.0** Rheumatoid arthritis **720.0** Ankylosing Spondylitis
 moderate severe Crohn's Disease
 Other (specify & include ICD-9) _____
- PATIENT INFORMATION:**
 a. Does the patient have a current infection? Yes No
 b. Has the patient tried phototherapy? Yes No
 c. Has the patient been evaluated (i.e. tuberculin test)? Yes No
- PATIENT HISTORY**
 a. History of systemic malignancy? Yes No
 (specify) _____
 b. Pregnant or planning to become pregnant? Yes No N/A
 c. Previous 12-week cycle of Amevive®? Yes No N/A
 d. Concurrently on phototherapy? (**Amevive only**) Yes No N/A
 (specify) _____
 e. Will Enbrel®, Kineret®, or Humira® be used concomitantly? Yes No N/A

Please list any previous or current therapies related to the diagnosis:

Drug name	Dates	Duration
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please add any other supporting medical information that may be useful in the decision-making process:

FAX TO (215) 761-9165 YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL

Internal use only	Vendor _____	Billing Code _____	M / Rx
Document # _____	LOB _____	Processor Initials _____	
M F Rx coverage Y N	STANDARD - SELECT	Date _____	
Previous Auth Y N	Auth# _____	From _____ To _____	
Approved	Reviewer Initials _____	Date _____	Coverage effective date / /