AmeriHealth

Prior Authorization Form

Arthritis/Psoriasis Agents

ONLY COMPLETED REQUESTS WILL BE REVIEWED

☐ **Enbrel®** ☐ **Kineret®** ☐ **Humira®** ☐ **Amevive®** ☐ **Raptiva®** ☐ **Simponi®** ☐ **Cimzia®**

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.

☐ **No Delivery Requested**	☐ **Delivery Requested**	
☐ **Physician Supply, authorization only [Flex series]**	☐ **Physician's office**	☐ **Patient's home**
☐ **Member Pick up at pharmacy if benefit available**	**Preferred Vendor:** _____	

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

1. **PHYSICIAN'S SPECIALTY (required)** ☐ Rheumatology ☐ Dermatology ☐ GI
   ☐ Other (specify all) _____
2. **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)_____

3. **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
4. **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

Document #_____

M F Rx coverage Y N

Previous Auth Y N

Vendor_____

LOB_____

STANDARD - SELECT

Auth#_____

Billing Code_____ **M / Rx**

Processor Initials_____

Date_____

From_____ To_____

AmeriHealth HMO, Inc. • AmeriHealth Insurance Company of New Jersey• QCC Insurance Company d/b/a AmeriHealth Insurance Company

Approved	**Reviewer Initials**_____	Date_____	Coverage effective date / /