AmeriHealth

Prior Authorization Form

Arthritis/Psoriasis Agents

ONLY COMPLETED REQUESTS WILL BE REVIEWED

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

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