

Today's date: \_\_\_\_\_

Intended date of injection: \_\_\_\_\_

## Prior Authorization Form – Yesintek®

Buy-and-bill requests for this drug should be submitted through NaviNet®.

**ONLY COMPLETED REQUESTS WILL BE REVIEWED.**

**Check one:**  New start     Continued treatment

**Patient information (please print)**

**Physician information (please print)**

|                     |        |                       |     |
|---------------------|--------|-----------------------|-----|
| Patient name        |        | Prescribing physician |     |
| Address             |        | Office address        |     |
| City, state, ZIP    |        | City, state, ZIP      |     |
| Patient telephone # |        | Office contact        |     |
| Patient ID          |        | Office telephone #    |     |
| Date of birth       | Weight | Fax #                 | NPI |

**This drug will be delivered to the requesting physician for the formulation selected below:**

**Prefilled syringe:** \_\_\_\_\_ 45mg    \_\_\_\_\_ 90mg    or    **Vial:** \_\_\_\_\_ 45mg    \_\_\_\_\_ 130mg

**\*\* A copy of the prescription must accompany the medication request for delivery.\*\***

**1) Diagnosis for drug requested (must include ICD-10):** \_\_\_\_\_

**2) Patient medical information**

**For Crohn's disease only**

- a. Does the patient have a documented history of failure, contraindication, or intolerance to at least one of the following? Check all that apply and list the drug(s) on the line provided below:  Yes     No
- Immunomodulators (e.g., azathioprine, 6-mercaptopurine, methotrexate); \_\_\_\_\_
- Corticosteroids (e.g., budesonide [Entocort® EC], prednisone, hydrocortisone, methylprednisolone); \_\_\_\_\_
- Anti-tumor necrosis factor agents (e.g., certolizumab pegol [Cimzia®], adalimumab [Humira®]); \_\_\_\_\_
- b. Had/Will the patient receive one intravenous infusion before switching to subcutaneous injections?  Yes     No

**For plaque psoriasis only**

- a. Is the patient's chronic plaque psoriasis classified as moderate-to-severe?  Yes     No
- b. Does the patient have a documented history of failure, contraindication, or intolerance to any of the following?  Yes     No  
Check all that apply and list the drug(s) on the line provided below:
- Topical steroids available by prescription only; \_\_\_\_\_
- Topical nonsteroids available by prescription only (e.g., topical calcipotriene [Dovonex®], topical anthralin, topical retinoids [Tazorac®]); \_\_\_\_\_
- Topical immunomodulators (e.g., pimecrolimus [Elidel®], tacrolimus [Protopic®]); \_\_\_\_\_
- Methotrexate; \_\_\_\_\_
- Oral retinoids (e.g., Soriatane®); \_\_\_\_\_
- Cyclosporine (e.g., Neoral, Gengraf); \_\_\_\_\_

**For psoriatic arthritis only**

- a. Does the patient have a documented history of failure, contraindication, or intolerance to any disease-modifying antirheumatic drug (DMARD) such as, but not limited to, sulfasalazine, azathioprine, hydroxychloroquine, cyclosporine, methotrexate, or anti-tumor necrosis factor agents?  Yes     No  
If yes, list drug(s): \_\_\_\_\_

**3) Prescription information**

Quantity \_\_\_\_\_ refill x \_\_\_\_\_ month(s)

Instructions (include dose) \_\_\_\_\_ every \_\_\_\_\_ day(s)/ week(s)/ month(s)

Physician's signature \_\_\_\_\_

**Please fax this completed form to 215-761-9580.**