



Prior Authorization Form
Arthritis/Psoriasis Agents

ONLY COMPLETED REQUESTS WILL BE REVIEWED

- Enbrel, Kineret, Humira, Amevive, Raptiva, Simponi, Cimzia, Actemra, Remicade (North Penn group only)

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'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
2. DIAGNOSIS FOR DRUG REQUESTED 696.1 Chronic plaque psoriasis, 696.0 Psoriatic arthritis, 714.0 Rheumatoid arthritis, 720.0 Ankylosing Spondylitis
3. PATIENT INFORMATION: a. Does the patient have a current infection? b. Has the patient tried phototherapy? c. Has the patient been evaluated (i.e. tuberculin test)?
4. PATIENT HISTORY a. History of systemic malignancy? b. Pregnant or planning to become pregnant? c. Previous 12-week cycle of Amevive? d. Concurrently on phototherapy? (Amevive only) e. Will Enbrel, Kineret, or Humira be used concomitantly?

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

Table with 3 columns: 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