



Prior Authorization Form Arthritis/Psoriasis Agents

ONLY COMPLETED REQUESTS WILL BE REVIEWED

- Enbrel® Kineret® Humira® Amevive® Raptiva® Simponi® Cimzia®
 Actemra® Orencia® Remicade®

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'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****

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 Ulcerative colitis Juvenile arthritis
 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 (888) 671-5285 YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL