FUTURE SCRIPTS

Please complete ALL information below and fax your request to 1-888-671-5285

Rasuvo® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the diagnosis below:

- ❑ Active polyarticular juvenile idiopathic arthritis
- ❑ Severe, active rheumatoid arthritis
- ❑ Severe psoriasis
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Has the patient had a trial and failure or intolerance to oral methotrexate? ❑ **Yes** ❑ **No**

Select if Rasuvo is prescribed by or in consultation with one of the following specialists:

- ❑ Dermatologist
- ❑ Rheumatologist

Reauthorization:

If this is a reauthorization request, answer the following question:

Is there documentation the patient has had a positive clinical response to Rasuvo therapy? ❑ **Yes** ❑ **No**

Quantity Limit Requests:

What is the quantity requested per MONTH? _____

What is the reason for exceeding the plan limitations?

- ❑ Titration or loading dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ Other: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.