



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:	
<input type="checkbox"/> Check if generic substitution is acceptable			Directions for Use:		
<input type="checkbox"/> Check if request is for continuation of therapy					
Clinical Information (required)					
<b>Select the diagnosis below:</b>					
<input type="checkbox"/> Active polyarticular juvenile idiopathic arthritis					
<input type="checkbox"/> Severe, active rheumatoid arthritis					
<input type="checkbox"/> Severe psoriasis					
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
<b>Clinical Information:</b>					
Has the patient had a trial and failure or intolerance to oral methotrexate? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Select if Rasuvo is prescribed by or in consultation with one of the following specialists:					
<input type="checkbox"/> Dermatologist					
<input type="checkbox"/> Rheumatologist					
<b>Reauthorization:</b>					
<b>If this is a reauthorization request, answer the following question:</b>					
Is there documentation the patient has had a positive clinical response to Rasuvo therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>Quantity Limit Requests:</b>					
What is the quantity requested per MONTH? _____					
<b>What is the reason for exceeding the plan limitations?</b>					
<input type="checkbox"/> Titration or loading dose purposes					
<input type="checkbox"/> 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)					
<input type="checkbox"/> Requested strength/dose is not commercially available					
<input type="checkbox"/> 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.

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