FUTURE SCRIPTS

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

Otrexup® & 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	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

- ❑ Plaque psoriasis
- ❑ Polyarticular Juvenile Idiopathic Arthritis (PJIA)
- ❑ Psoriatic Arthritis
- ❑ Rheumatoid Arthritis
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Prescriber's Specialty:

Select if the requested medication is recommended by one of the following specialists:

- ❑ Dermatologist
- ❑ Rheumatologist

For plaque psoriasis, answer the following:

Does the patient have severe psoriasis? ❑ **Yes** ❑ **No**

Has the patient had inadequate response to ALL other standard therapy (e.g., oral methotrexate, all topical therapy modalities, phototherapy, etc.)? ❑ **Yes** ❑ **No**

For polyarticular juvenile idiopathic arthritis (PJIA) or psoriatic arthritis, answer the following:

Does the patient have inadequate response or inability to tolerate oral methotrexate? ❑ **Yes** ❑ **No**

For rheumatoid arthritis, answer the following:

Does the patient have severe, active rheumatoid arthritis? ❑ **Yes** ❑ **No**

Does the patient have inadequate response or inability to tolerate oral methotrexate? ❑ **Yes** ❑ **No**

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.