

Beneficiary Information

1. Beneficiary Last Name: _____	2. First Name: _____	
3. Beneficiary ID #: _____	4. Beneficiary Date of Birth: _____	5. Beneficiary Gender: _____

Prescriber Information

6. Prescriber Name: _____	NPI #: _____		
Mailing address: _____	City: _____	State: _____	ZIP: _____
7. Requester Contact Information: _____			
Name: _____	Phone #: _____	Fax #: _____	

Drug Information

8. Drug Name: _____	9. Dose: _____	10. Directions: _____
11. Length of Therapy: <input type="checkbox"/> up to 30 days <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <input type="checkbox"/> 120 days <input type="checkbox"/> 180 days <input type="checkbox"/> 365 days <input type="checkbox"/> Other: _____		

Clinical Information

Request for Rheumatoid Arthritis:

1. Does the beneficiary have a diagnosis of Rheumatoid Arthritis? Yes ___ No ___
2. Is the beneficiary on another injectable biologic immunomodulator? Yes ___ No ___
3. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection? Yes ___ No ___
4. Has the beneficiary been tested with Hep B SAG and Core Ab? Yes ___ No ___
5. Has the beneficiary experienced a therapeutic failure/inadequate response with methotrexate or at least one disease modifying antirheumatic drug (e.g., leflunomide, hydroxychloroquine, minocycline, sulfasalazine)? Yes ___ No ___
6. Is the beneficiary unable to receive methotrexate or disease modifying antirheumatic drug due to contraindications or intolerabilities? Yes ___ No ___
7. Does the beneficiary have clinical evidence of severe or rapidly progressing disease? Yes ___ No ___
8. Has the beneficiary had a trial and failure of Enbrel or Humira or a clinical reason beneficiary cannot try Enbrel or Humira? Yes ___ No ___

Request for FDA Approved Diagnosis Not Listed Above:

1. Diagnosis: _____
2. Is the beneficiary another injectable biologic immunomodulator? Yes ___ No ___
3. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection? Yes ___ No ___
4. Has the beneficiary been tested with Hep B SAG and Core Ab? Yes ___ No ___

Signature of Prescriber: _____

Date: _____

***Prescriber signature mandatory**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406