

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: ___ up to 30 days ___ 60 days ___ 90 days ___ 120 days ___ 180 days ___ 365 days ___ Other: _____

Clinical Information

Request for Polyarticular Juvenile Idiopathic Arthritis (PJIA):

1. Does the beneficiary have a diagnosis of Polyarticular Juvenile Idiopathic 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 tried one systemic corticosteroid (e.g., prednisone, methylprednisolone) or methotrexate, leflunomide or sulfasalazine with inadequate response or is unable to take these therapies due to contraindications? Yes ___ No ___
6. Does the beneficiary have PJIA subtype enthesitis related arthritis? Yes ___ No ___
7. 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 Psoriatic Arthritis:

1. Does the beneficiary have a documented definitive diagnosis of Psoriatic Arthritis? Yes ___ No ___
2. Is the beneficiary 18 years of age or older? Yes ___ No ___
3. Is the beneficiary on another injectable biologic immunomodulator? Yes ___ No ___
4. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection? Yes ___ No ___
5. Has the beneficiary been tested with Hep B SAG and Core Ab? Yes ___ No ___
6. Does the beneficiary have a documented inadequate response or inability to take methotrexate? Yes ___ No ___
7. Has the beneficiary had a trial and failure of Cosentyx, Enbrel or Humira or a clinical reason beneficiary cannot try Cosentyx, Enbrel or Humira? Yes ___ No ___

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 ___

Prophylaxis of acute Graft versus Host Disease (aGVHD):

1. Is the beneficiary undergoing hematopoietic stem cell transplantation (HSCT) from a matched or **one** allele-mismatched unrelated-donor? Yes ___ No ___
2. Is the beneficiary 2 years of age or older? Yes ___ No ___
3. Is the beneficiary taking in combination with a calcineurin inhibitor and methotrexate? Yes ___ No ___
4. Is the beneficiary on another injectable biologic immunomodulator? Yes ___ No ___
5. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection? Yes ___ No ___

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

6. Has the beneficiary been tested with Hep B SAG and Core Ab? Yes ___ No ___

Request for FDA Approved Diagnosis Not Listed Above:

1. Diagnosis: _____

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 ___

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.