

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 Ankylosing Spondylitis:

1. Does the beneficiary have a diagnosis of Ankylosing Spondylitis? 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 inadequate symptom relief from treatment with at least two NSAIDs? Yes ___ No ___
6. Is the beneficiary unable to receive treatment with NSAIDs due to contraindications? 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 Cosentyx, Enbrel or Humira or a clinical reason beneficiary cannot try Cosentyx, Enbrel or Humira? Yes ___ No ___

Request for Crohn's Disease:

1. Does the beneficiary have a diagnosis of moderate to severe Crohn's Disease? 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 had a trial and failure of Humira, or a clinical reason beneficiary cannot try Humira? Yes ___ No ___

Request for Plaque Psoriasis (Adult):

1. Does the beneficiary have a documented definitive diagnosis of moderate-to-severe Chronic Plaque Psoriasis? 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 body surface area (BSA) involvement of at least 3%? Yes ___ No ___
7. Does the beneficiary have involvement of the palms, soles, head and neck, or genitalia, causing disruption in normal daily activities and/or employment? Yes ___ No ___
8. Has the beneficiary failed to respond to, or has been unable to tolerate phototherapy and **ONE** of the following medications, or beneficiary has contraindications to these treatments: Soriatane (acitretin), Methotrexate, and/or Cyclosporine? Yes ___ No ___
9. 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 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 ___

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

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 Ulcerative Colitis:

1. Does the beneficiary have a diagnosis of ulcerative colitis? 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 had a trial and failure of Humira, or a clinical reason beneficiary cannot try Humira? 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.