



**Independence  
Blue Cross**

**Prior Authorization Form  
Arthritis/Psoriasis Agents**

**ONLY COMPLETED REQUESTS WILL BE REVIEWED**

Enbrel®     Kineret®     Humira®     Amevive®     Raptiva®     Simponi®     Cimzia®

Quantity \_\_\_\_\_ Refill x \_\_\_\_\_ months

Instructions \_\_\_\_\_

Physician's signature \_\_\_\_\_ Provider NPI: \_\_\_\_\_ MD# \_\_\_\_\_

Date: \_\_\_\_\_ Date medication needed \_\_\_\_\_

**Patient Information**

Patient's name \_\_\_\_\_  
Patient's address \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Patient's phone # \_\_\_\_\_  
Patient's ID#: \_\_\_\_\_ DOB \_\_\_\_\_

**Prescriber Information**

Prescribing physician \_\_\_\_\_  
Office address \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Office contact \_\_\_\_\_  
Office # \_\_\_\_\_ Fax# \_\_\_\_\_

Upon approval, delivery is available. Complete section below.

<input type="checkbox"/> No Delivery Requested	<input type="checkbox"/> Delivery Requested
<input type="checkbox"/> Physician Supply, authorization only [Flex series]	<input type="checkbox"/> Physician's office <input type="checkbox"/> Patient's home
<input type="checkbox"/> Member Pick up at pharmacy if benefit available	Preferred Vendor: _____

**\*\*A copy of the prescription must accompany the medication request\*\***

**1. PHYSICIAN'S SPECIALTY (required)**     Rheumatology     Dermatology     GI  
 Other (specify all) \_\_\_\_\_

**2. DIAGNOSIS FOR DRUG REQUESTED**

696.1 Chronic plaque psoriasis     696.0 Psoriatic arthritis     714.0 Rheumatoid arthritis     720.0 Ankylosing Spondylitis  
 moderate     severe     Crohn's Disease  
 Other (specify & include ICD-9) \_\_\_\_\_

**3. PATIENT INFORMATION:**

a. Does the patient have a current infection?     Yes     No  
b. Has the patient tried phototherapy?     Yes     No  
c. Has the patient been evaluated (i.e. tuberculin test)?     Yes     No

**4. PATIENT HISTORY**

a. History of systemic malignancy?     Yes     No  
(specify) \_\_\_\_\_  
b. Pregnant or planning to become pregnant?     Yes     No     N/A  
c. Previous 12-week cycle of Amevive®?     Yes     No     N/A  
d. Concurrently on phototherapy? (Amevive only)     Yes     No     N/A  
(specify) \_\_\_\_\_  
e. Will Enbrel®, Kineret®, or Humira® be used concomitantly?     Yes     No     N/A

Please list any previous or current therapies related to the diagnosis:

Drug name	Dates	Duration
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please add any other supporting medical information that may be useful in the decision-making process:

\_\_\_\_\_  
\_\_\_\_\_

**FAX TO (215) 761-9165 YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL**

**Internal use only**

Document # \_\_\_\_\_

Vendor \_\_\_\_\_

LOB \_\_\_\_\_

Billing Code \_\_\_\_\_ M / Rx

Processor Initials \_\_\_\_\_

M	F	Rx coverage	Y	N	STANDARD - SELECT	Date_____
Previous Auth	Y	N	Auth#_____	From_____	To_____	
<b>Approved</b>		<b>Reviewer Initials</b>	_____	Date_____	Coverage effective date	/ /