



**Prior Authorization Form
Arthritis/Psoriasis Agents**

ONLY COMPLETED REQUESTS WILL BE REVIEWED

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

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