15 Earhart Drive, Suite 101, Amherst, NY 14221

RHEUMATOID ARTHRITIS AUTHORIZATION AND RE-AUTHORIZATION REQUEST

TEL: (716) 929-1000 | 1-800-809-4763 FAX: (716) 532-7360

Member Name:	Today's Date:	Date Needed:	
Date of birth: Sex: Weight:		Prescriber:	Hospital/Clinic:
Home Phone Number: ( )		Phone Number: ( )	Fax Number: ( )
Home Address:	City: State: Zip:	Address:	City: State: Zip:
Payor: ☐ Independent Health ☐ Anne Arundel Health System ☐ Pharmacy Benefit Dimensions ☐ Commercial ☐ Medicare ☐ Medicaid ☐ Self-funded Insurance ID:	Group Number:	Prescriber specialty:	
		Allergies:	

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: _____ICD10 Code: _____

Has patient tried and failed to tolerate or respond to a 3 month trial of a below listed conventional agent? (Methotrexate, leflunomide, sulfasalazine, hydroxychloroquine)

☐ Yes ☐ No Name and length of therapy_____

_____

Please list all other previous therapies:

_____

_____

_____

Has the patient been screened for latent TB infection or interferon-gamma release assays? (TB Testing is not required for Otezla)

☐ Yes ☐ No

Attach baseline tuberculosis test result.

If the test is positive, then submit evidence that:

- Patient must be evaluated for latent tuberculosis before initiating BDAID therapy (latent tuberculosis should be treated before starting) AND
- Submission of yearly screening for latent TB such as annual TB skin testing results or chest x-ray, is required for patients who live, travel, or work in situations where TB exposure is likely while on treatment OR for those who have previously tested positive.

DRUG SELECTION

☐ New Authorization Request ☐ Reauthorization Request

☐ **ACTEMRA** ☐ **CIMZIA** ☐ **ENBREL**

☐ **HUMIRA** ☐ **KEVZARA** ☐ **KINERET**

☐ **OLUMIANT** ☐ **ORENCIA** ☐ **REMICADE**

☐ **RINVOQ** ☐ **SIMPONI** ☐ **XELJANZ**

☐ **ADALIMUMAB-ADAZ** ☐ **HADLIMA (ADALIMUMAB-BWWD)**

☐ **OTHER**_____

☐ Initial Dose: _____ Frequency: _____

☐ Maintenance Dose: _____ Frequency: _____

Will medication be self-injected? ☐ Yes ☐ No

For reauthorization:

-Patient continues to meet initiation criteria? ☐ Yes ☐ No

- Absence of inexplicable toxicity from the drug? ☐ Yes ☐ No

-Ongoing monitoring for TB as noted under criteria for authorization? ☐ Yes ☐ No

-Clinical response or remission of disease maintained with continued use? ☐ Yes ☐ No

☐ OTREXUP ☐ RASUVO ☐ REDITREX

DOSE:_____ FREQUENCY:_____

- Medication is requested for the symptomatic control of severe, recalcitrant, disabling psoriasis in adults who are not adequately responsive to other forms of therapy? ☐ Yes ☐ No
- Medication is requested for the treatment of an adult patient with severe active RA? ☐ Yes ☐ No
- ☐ Yes ☐ No
- Patient is intolerant of or had an inadequate response to first-line therapy? ☐ Yes ☐ No
- Submission of negative pregnancy test result for women of reproductive potential? ☐ Yes ☐ No
- Patient has tried and failed to respond to or tolerate oral MTX? ☐ Yes ☐ No
- Patient has tried and failed to respond to or tolerate MTX sodium solution for injection? ☐ Yes ☐ No
- Submission of baseline complete blood counts, renal functions and liver function tests? ☐ Yes ☐ No
- Confirmation that CBC, renal functions and liver function tests are scheduled to be monitored periodically while on therapy? ☐ Yes ☐ No