45 Earhart Drive, Suite 110, 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:
Member's Insurance ID:		Office Phone :	Office Fax Number:
Allergies:		Office Contact:	

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_____

_____

Has patient had an updated TB test within the last year?
☐ Yes ☐ No

Date of test: _____ Result:_____

Other previous treatments: _____

_____

Clinical impression: _____

_____

For reauthorization: Clinical response or remission of disease maintained with continued use? ☐ Yes ☐ No

DRUG SELECTION

☐ New Authorization Request ☐ Reauthorization Request
☐ Urgent Request

☐ **ACTEMRA** ☐ **ENBREL** ☐ **HUMIRA**

☐ **XELJANZ** ☐ **CIMZIA** ☐ **KEVZARA**

☐ **KINERET** ☐ **ORENCIA** ☐ **SIMPONI**

☐ **REMICADE** ☐**OLUMIANT** ☐ **OTHER**_____

☐ **Initial** Dose: _____ Frequency: _____

☐ **Maintenance** Dose: _____ Frequency: _____

Will medication be self-injected? ☐ Yes ☐ No

OTREXUP/RASUVO

☐ **OTREXUP** ☐ **RASUVO**

DOSE:_____ **FREQUENCY:**_____

- Patient has severe active RA?
  ☐ Yes ☐ No
- Submission of negative pregnancy test?
- ☐ Yes ☐ No
- Patient has tried and failed to respond to oral MTX; and 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