reliance|rx℠
15 Earhart Drive, Suite 101, Amherst, NY 14221

ANKYLOSING SPONDYLITIS 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:	Speciality:
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

ICD10 Code:_____

Will medication be self-injected? ☐ Yes ☐ No

Current Treatment_____

- Has the patient tried and failed to respond to any of the listed conventional agents? (NSAIDs, Sulfasalazine, Intraarticular corticosteroid therapy) ☐ Yes ☐ No
  -If yes, list prior treatments:
  _____
  _____
- TB Skin test result: _____ Date: _____
- Prior Treatments_____
  _____

For Reauthorization:

-Does patient continue to meet initiation criteria including ongoing TB monitoring? ☐ Yes ☐ No

-Is patient in absence of toxicity from the drug? ☐ Yes ☐ No

-Has the patient shown a clinical response or remission? ☐ Yes ☐ No

DRUG SELECTION

☐ New Authorization ☐ Reauthorization Request

☐ **ENBREL** ☐ **HUMIRA**

☐ **REMICADE** ☐ **COSENTYX**

☐ **SIMPONI** ☐ **CIMZIA**

☐ **OTHER**_____

☐ Initial Dose: _____

Frequency: _____

☐ Maintenance Dose: _____

Frequency: _____