



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Juvenile Idiopathic Arthritis (OAA)

Phone: 800-728-7947

Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	Prescriber Name:	
	Supervising Physician:	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

<p>Q1. What drug is being requested?</p> <p><input type="checkbox"/> Actemra (tocilizumab) - IV Formulation</p> <p><input type="checkbox"/> Enbrel (etanercept)</p> <p><input type="checkbox"/> Humira (adalimumab)</p> <p><input type="checkbox"/> Orenia (abatacept)- IV Formulation</p>
<p>Q2. What diagnosis is this drug being prescribed for (pick one)?</p> <p><input type="checkbox"/> POLYARTICULAR juvenile idiopathic arthritis (JIA) [proceed to Q3-7]</p> <p><input type="checkbox"/> SYSTEMIC juvenile idiopathic arthritis (JIA) [proceed to Q3-4, 8]</p> <p><input type="checkbox"/> Other</p>
<p>Q3. Please provide ICD code(s) for diagnosis.</p>
<p>Q4. Is the prescriber a Rheumatologist?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q5. If the diagnosis is POLYARTICULAR JIA, has the patient failed or does the patient have a contraindication to methotrexate, sulfasalazine, or leflunomide?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>



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Patient Name:	Prescriber Name: Supervising Physician:
Q6. If the diagnosis is POLYARTICULAR JIA, has the patient failed another anti-TNF agent? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q7. If the diagnosis is POLYARTICULAR JIA, and the request is for ACTEMRA – IV or ORENCIA – IV, has the patient failed Enbrel or Humira? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q8. If diagnosis is SYSTEMIC JIA, has the patient failed or does the patient have a contraindication to NSAIDs, glucocorticoids, or Kineret? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q9. Additional Comments	

Prescriber Signature

Date

☐ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to the SWHP medical director at 1-888-316-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.

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