

PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Ankyl Spondylitis & Psoriatic Arth (SAA)

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.

	Prescriber Name:		
Patient 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.			
Q1. What drug is being requested?			
☐ Cimzia (certolizumab)			
☐ Enbrel (etanercept)			
☐ Humira (adalimumab)			
☐ Simponi (golimumab) - SubQ Formulation			
Q2. What diagnosis is this drug being prescribed for (pick one)?			
☐ Psoriatic arthritis			
☐ Ankylosing spondylitis			
Other			
Q3. Please provide ICD code(s) for diagnosis.			
Q4. Please indicate location of administration.			
☐ Home			
☐ Long Term Care (LTC) facility			
☐ Physician office (drug from office stock)			



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		Prescriber Name:	
Patient Name:		Supervising Physician:	
Physician office (drug from pharmacy with a prescription)			
Q5. Is the prescriber a Rheuma	atologist?		
☐ Yes [□ No		
Q6. Is the prescriber a Dermato	ologist?		
☐ Yes [□ No		
Q7. Does the member have documented spinal involvement?			
☐ Yes [□ No		
Q8. Has the patient previously failed or have a contraindication to nonsteroidal anti-inflammatory drugs (NSAIDs)?			
☐ Yes [□ No		
Q9. Has the patient previously failed methotrexate?			
☐ Yes [□ No		
Q10. If the patient has NOT previously FAILED METHOTREXATE, does the patient have a CONTRAINDICATION to methotrexate?			
☐ Yes [□ No		
Q11. If the patient has a CONTRAINDICATION to METHOTREXATE, has the patient FAILED AT LEAST ONE, or does the patient have CONTRAINDICATION(S) to OTHER DMARDs (hydroxychloroquine, sulfasalazine, leflunomide)?			
☐ Yes [□ No		
Q12. If the request is for CIMZIA or SIMPONI, is the patient a NEW START?			
☐ Yes [□ No		
Q13. If the request is for CIMZI Yes – Enbrel & Humira No – Enbrel only No– Humira only No	A or SIMPONI, has the pation	ent failed Enbrel AND Humira?	
Q14. Additional Comments			



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