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.**

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.

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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☐ Physician office (drug from pharmacy with a prescription)

Q5. Is the prescriber a Rheumatologist?

☐ Yes ☐ No

Q6. Is the prescriber a Dermatologist?

☐ 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 CIMZIA or SIMPONI, has the patient failed Enbrel AND Humira?

☐ Yes – Enbrel & Humira
☐ No – Enbrel only
☐ No– Humira only
☐ No

Q14. Additional Comments

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Patient Name:	**Prescriber Name:** **Supervising Physician:**

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.