PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Ankylosing Spondylitis & Psoriatic Arthritis

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 200 MG VIAL KIT (GCN 99615)
- ☐ Cimzia 200 MG SYRINGE KIT (GCN 23471)
- ☐ Enbrel 25 MG VIAL (GCN 52651)
- ☐ Enbrel 25 MG/0.5 ML SYRINGE (GCN 98398)
- ☐ Enbrel 50 MG/ML SYRINGE (GCN 23574)
- ☐ Enbrel 50 MG/ML MINI CARTRIDGE (GCN 43924)
- ☐ Enbrel 50 MG/ML SURECLICK PEN (GCN 97724)
- ☐ Humira 40 MG/0.8 ML PEN (GCN 97005)
- ☐ Humira 40 MG/0.8 ML SYRINGE (GCN 18924)
- ☐ Humira PEN CROHN-UC-HS 40 MG (GCN 97005)
- ☐ Humira PEN PSORIA-UVEITIS 40MG (GCN 97005)
- ☐ Humira 40 MG/0.4 ML PEN Citrate free/Low volume (GCN 43506)
- ☐ Humira 40 MG/0.4 ML SYRINGE Citrate free/Low volume (GCN 43505)
- ☐ Humira PEN CROHN-UC-HS 80 MG Citrate free/Low volume (GCN 44014)
- ☐ Humira PEN PSOR-UVEI 80MG-40MG Citrate free/Low volume (GCN 44954)
- ☐ Orencia 125 MG/ML SYRINGE (GCN 30289)
- ☐ Orencia 125 MG/ML CLICKJECT (GCN 41656)
- ☐ Orencia 250 MG VIAL (GCN 26306)
- ☐ Simponi 50 MG/0.5 ML SYRINGE (GCN 22536)
- ☐ Simponi 50 MG/0.5 ML PEN (GCN 22533)
- ☐ Simponi 100 MG/ML SYRINGE (GCN 34697)
- ☐ Simponi 100 MG/ML PEN (GCN 35001)
- ☐ Simponi ARIA 50 MG/4 ML VIAL (GCN 34983)
- ☐ Other (Please specify)

Scott&White HEALTH PLAN
PART OF BAYLOR SCOTT & WHITE HEALTH

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Q2. What are the quantity and days supply requested?

Q3. Is the patient a new start to therapy?

☐ Yes ☐ No

Q4. What diagnosis is this drug being prescribed for (pick one)?

☐ Psoriatic arthritis
☐ Ankylosing spondylitis
☐ Other

Q5. Please provide ICD code(s) for diagnosis.

Q6. Is the prescriber a Rheumatologist?

☐ Yes ☐ No

Q7. Is the prescriber a Dermatologist?

☐ Yes ☐ No

Q8. Does the patient have documented spinal involvement?

☐ Yes ☐ No

Q9. If request is for ankylosing spondylitis, has the patient previously failed an adequate of or have a contraindication to nonsteroidal anti-inflammatory drugs (NSAIDs)?

☐ Yes ☐ No

Q10. If request is for psoriatic arthritis, has patient failed an adequate trial of or have clinically significant intolerance to methotrexate (MTX)?

☐ Yes ☐ No

Q11. If request is for psoriatic arthritis, does the patient have a contraindication to methotrexate (MTX)?

☐ Yes (Please specify) ☐ No

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Q12. If request is for psoriatic arthritis and patient has a contraindication to methotrexate, does the patient have failure of an adequate trial to the following? Please select all that apply

☐ hydroxychloroquine ☐ sulfasalazine ☐ leflunomide

Q13. If request is for psoriatic arthritis and patient has a contraindication to methotrexate, does the patient have contraindication to the following? Please select all that apply

☐ hydroxychloroquine ☐ sulfasalazine ☐ leflunomide

Q14. If the request is for CIMZIA, ORENCIA, or SIMPONI, has the patient had failure of an adequate trial, intolerance, or contraindication to Enbrel AND Humira?

☐ Yes – Enbrel & Humira
☐ No – Enbrel only
☐ No – Humira only
☐ No - other (please specify)

Q15. Who is the ENTITY that will be submitting the CLAIM for the DRUG and seeking reimbursement?

☐ Pharmacy
☐ Individual prescriber
☐ Provider or specialty group
☐ Facility
☐ Other (please specify)

Q16. Provide name and NPI of the billing entity

Q17. Will the claim for the drug be submitted as a MEDICAL claim or PHARMACY claim (Note: If a pharmacy will be submitting a MEDICAL claim for drug reimbursement, answer MEDICAL)?

☐ Medical ☐ Pharmacy

Q18. Additional Comments

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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 a SWHP pharmacist or medical director at 1-800-728-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.