PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Juvenile Idiopathic Arthritis (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?

- ☐ Actemra 162 MG/0.9 ML SYRINGE (GCN 35486)
- ☐ Actemra 80 MG/4 ML VIAL (GCN 27366)
- ☐ Actemra 200 MG/10 ML VIAL (GCN 27367)
- ☐ Actemra 400 MG/20 ML VIAL (GCN 27368)
- ☐ 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)
- ☐ Other (Please specify)

Q2. What are the quantity and days supply requested?

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

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Q3. Is the patient a new start to therapy? If no, please provide start date.

☐ Yes ☐ No

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

☐ POLYARTICULAR juvenile idiopathic arthritis (JIA)
☐ SYSTEMIC juvenile idiopathic arthritis (JIA)
☐ Other

Q5. Please provide ICD-9 code(s) for diagnosis.

Q6. Is the prescriber a Rheumatologist?

☐ Yes ☐ No

Q7. If the diagnosis is POLYARTICULAR JIA, has the patient failed an adequate trial of at least one of the following: methotrexate, sulfasalazine, or leflunomide?

☐ Yes ☐ No

Q8. If the diagnosis is POLYARTICULAR JIA, does the patient have clinically significant intolerance or contraindication to ALL of the following: methotrexate, sulfasalazine, AND leflunomide?

☐ Yes ☐ No

Q9. If the diagnosis is POLYARTICULAR JIA, does the patient have failure of an adequate trial, clinically significant intolerance, or contraindication to the following? Please select all that apply.

☐ Enbrel
☐ Humira
☐ Other (please specify)
☐ No anti-TNF agents tried

Q10. If diagnosis is SYSTEMIC JIA, has the patient failed or does the patient have a contraindication to NSAIDs, glucocorticoids, or Kineret?

☐ Yes ☐ No

Q11. Who is the ENTITY that will be submitting the CLAIM for the DRUG and seeking reimbursement?

☐ Pharmacy

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

Q12. Provide name and NPI of the billing entity

Q13. 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

Q14. 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 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.

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