15 Earhart Drive, Suite 101, Amherst, NY 14221

ANKYLOSING SPONDYLITIS AUTHORIZATION AND RE-AUTHORIZATION REQUEST

TEL: (716) 929-1000 | 1-800-809-4763 FAX: (716) 532-7360

Member Name:	Today's Date:	Date Needed:	
Date of birth: Sex: Weight:		Prescriber:	Hospital/Clinic:
Home Phone Number: ( )		Phone Number: ( )	Fax Number: ( )
Home Address: City: State: Zip:		Address:	City: State: Zip:
Member's Insurance ID:		Office Phone :	Office Fax Number:
Allergies:		Office Contact:	

STATEMENT OF MEDICAL NECESSITY

ICD10 Code:_____

Will medication be self-injected? ☐ Yes ☐ No

- Has the patient tried and failed to respond to a 3 month trial of one of the below medications? ☐ Yes ☐ No
  If yes, please select all that apply:

  ☐ **NSAIDS**

  ☐ **SULFASALAZINE**

  ☐ **INTRAARTICULAR CORTICOSTEROID THERAPY**

- Please list all prior treatments and length of therapy:

Medication Name	Therapy Dates	Results

- TB Skin test result: _____
  Date: _____

DRUG SELECTION

☐ New Authorization ☐ Reauthorization Request

☐ Initial Dose: _____ Frequency: _____

☐ Maintenance Dose: _____ Frequency: _____

☐ **CIMZIA** ☐ **COSENTYX**

☐ **ENBREL** ☐ **HUMIRA**

☐ **REMICADE** ☐ **SIMPONI**

☐ **SIMPONI ARIA** ☐ **TALTZ**

☐ **OTHER** _____

For Reauthorization:

-Does patient continue to meet initiation criteria including ongoing TB monitoring? ☐ Yes ☐ No

-Is patient in absence of toxicity from the drug? ☐ Yes ☐ No

-Has the patient shown a clinical response or remission? ☐ Yes ☐ No