reliance|rx℠

45 Earhart Drive, Suite 110, Amherst, NY 14221

ULCERATIVE COLITIS AND CROHN'S 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: Specialty:
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:	
Is patient self-injecting? ☐ Yes ☐ No	Office Contact:

STATEMENT OF MEDICAL NECESSITY

ICD 10 Code_____ Primary Diagnosis:_____

TB Skin Test Result:_____ Date:_____

Has the patient tried and failed to respond to a 3 month trial of 1 of the below conventional agents?

(Methotrexate, Azathioprine, Aminosalicylate class, 6-mercaptopurine, corticosteroids (including budesonide EC capsule), Metronidazole, Cyclosporine, Ciprofloxacin)

☐ Yes ☐ No

If yes, please prior treatments and dates_____

_____

_____

Other Prior Treatments_____

_____

_____

For Ulcerative Colitis or Crohn's Disease 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 of remission? ☐ Yes ☐ No

DRUG SELECTION

☐ New Authorization Request ☐ Reauthorization Request

Ulcerative Colitis:

☐ **ENTYVIO** ☐ **HUMIRA** ☐ **REMICADE**

☐ **SIMPONI** ☐ **XELJANZ** ☐ **OTHER**_____

Crohn's Disease

☐ **STELARA** ☐ **CIMZIA** ☐ **ENTYVIO**

☐ **HUMIRA** ☐ **REMICADE** ☐ **OTHER**_____

☐ Initial Dose: _____

Frequency: _____

☐ Maintenance Dose: _____

Frequency: _____