



15 Earhart Drive, Suite 101, Amherst, NY 14221

# RHEUMATOID ARTHRITIS 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	DRUG SELECTION
Primary Diagnosis: _____ ICD10 Code: _____ Has patient tried and failed to tolerate or respond to a 3 month trial of a below listed conventional agent? (Methotrexate, leflunomide, sulfasalazine, hydroxychloroquine) <input type="checkbox"/> Yes <input type="checkbox"/> No Name and length of therapy _____ _____ Has patient had an updated TB test within the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of test: _____ Result: _____ Other previous treatments: _____ _____ Clinical impression: _____ _____ For reauthorization: Clinical response or remission of disease maintained with continued use? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> New Authorization Request <input type="checkbox"/> Reauthorization Request  <input type="checkbox"/> <b>ACTEMRA</b> <input type="checkbox"/> <b>ENBREL</b> <input type="checkbox"/> <b>HUMIRA</b> <input type="checkbox"/> <b>XELJANZ</b> <input type="checkbox"/> <b>CIMZIA</b> <input type="checkbox"/> <b>KEVZARA</b> <input type="checkbox"/> <b>KINERET</b> <input type="checkbox"/> <b>ORENCIA</b> <input type="checkbox"/> <b>SIMPONI</b> <input type="checkbox"/> <b>REMICADE</b> <input type="checkbox"/> <b>OLUMIANT</b> <input type="checkbox"/> <b>OTHER</b> _____  <input type="checkbox"/> <b>Initial</b> Dose: _____ Frequency: _____ <input type="checkbox"/> <b>Maintenance</b> Dose: _____ Frequency: _____  Will medication be self-injected? <input type="checkbox"/> Yes <input type="checkbox"/> No

OTREXUP/RASUVO
<input type="checkbox"/> <b>OTREXUP</b> <input type="checkbox"/> <b>RASUVO</b> <b>DOSE:</b> _____ <b>FREQUENCY:</b> _____
<ul style="list-style-type: none"> <li>• Patient has severe active RA? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>• Submission of negative pregnancy test? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>• Patient has tried and failed to respond to oral MTX; and MTX sodium solution for injection? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>• Submission of baseline complete blood counts, renal functions and liver function tests? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>• Confirmation that CBC, renal functions and liver function tests are scheduled to be monitored periodically while on therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> </ul>