

ARAVA / ENBREL/ KINERET

Prior Authorization Form

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services.

Otherwise please return completed form to:

UPMC HEALTH PLAN PHARMACY SERVICES PHONE 800-979-UPMC (8762)

FAX 412-454-7722

THIS SECTION FOR PROVIDER USE ONLY—PLEASE TYPE OR PRINT NEATLY

Please complete all sections of this form AND include details of past relevant medical treatment, which substantiates the need for an exception to using formulary alternatives, i.e. past prescription treatment failures, documented side effects, chart documentation, lab values, etc. Incomplete responses may delay this request.

Office Contact:		Provider Specialty: <input type="checkbox"/> Rheumatologist <input type="checkbox"/> Dermatologist <input type="checkbox"/> Other (Please List):		
Provider First Name:		Provider Last Name:		
Provider Phone:		Provider Fax:		
Patient Name:		Member UPMC Health Plan ID #:	Patient DOB:	Patient Age:
Drug Requested:	Strength:	Frequency:	Qty Dispensed:	
<input type="checkbox"/> Brand <input type="checkbox"/> Generic				
<input type="checkbox"/> New medication <input type="checkbox"/> Ongoing medication	If ongoing, provide date started:	If medication is ongoing, Did the member show improvement while on therapy?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Diagnosis:		Date of diagnosis:		
Place of infusion? (Name and Location)		Will the drug be: (select one)		
<input type="checkbox"/> Physician's Office:		<input type="checkbox"/> Billed directly by the provider via JCODE		
<input type="checkbox"/> Hospital/Facility:		If billed via JCODE, please provide the name of provider or vendor that will bill for this drug: _____		
		<input type="checkbox"/> Billed by a pharmacy and delivered to the provider		
		<input type="checkbox"/> Billed by a pharmacy and delivered to the patient		

Medical History

Rheumatoid Arthritis (RA)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, describe severity: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Psoriasis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, describe severity: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe AND % of BSA affected: <input type="checkbox"/> <10% <input type="checkbox"/> >10%
Psoriatic Arthritis (PA)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, describe severity: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe Number of affected joints: <input type="checkbox"/> <5 <input type="checkbox"/> >5
Ankylosing Spondylitis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, describe severity: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe Chart documentation must be submitted describing intensive conservative treatment measures tried and failed, including when indicated, a trial with a DMARD.
Other? (Please List)	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, describe severity: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe

Does patient have a history of Congestive Heart Failure (CHF)?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is patient currently receiving methotrexate therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No		If YES, start date:	
Has patient received methotrexate for at least 3-6 months with an inadequate response? <input type="checkbox"/> Yes <input type="checkbox"/> No		IF YES, start date:	End date:
Has patient experienced significant side effects/toxicity of methotrexate? <input type="checkbox"/> Yes <input type="checkbox"/> No		If YES, please specify:	
Does patient have contraindication to methotrexate? <input type="checkbox"/> Yes <input type="checkbox"/> No		If YES, please specify:	
Is patient using another TNF-blocking agent or other biologic agent in combination with drug requested? <input type="checkbox"/> Yes <input type="checkbox"/> No		If YES, please specify which medication and rationale for using combination therapy:	
Date of PPD (Tuberculosis) Test:		Result of PPD:	

History of formulary medications used to treat the above condition

Medication Trial/Previous Therapy	Date of Therapy Start Date End Date	Strength	Frequency	List adverse reactions/side effects/ reason for discontinuing