



PRIOR AUTHORIZATION REQUEST FORM
Biologic Therapy for Inflammatory Arthritis
 (Enbrel, Humira, Kineret, Orencia, Remicade, Rituxan & Cimzia)
REQUEST FOR INITIAL THERAPY

DATE OF REQUEST: _____

MEMBER INFORMATION

NAME _____

ID# _____

BIRTHDATE _____

PLEASE NOTE: By signing this form, you are attesting to the accuracy of the information provided, and that medical record documentation is available if requested.

PROVIDER INFORMATION

NAME _____

NPI # _____

ADDRESS _____

PHONE # _____ FAX# _____

CONTACT NAME _____

PROVIDER SIGNATURE _____

Drug Requested: Actemra Cimzia IV Cimzia SQ Enbrel Humira Kineret Orencia IV Orencia SQ
 Remicade Rituxan Simponi

Dose/frequency/duration of therapy: _____

Diagnosis _____ **ICD-9 code** _____

Please check one **Initial Therapy Request** **Continuation of Therapy Request**

If *not* obtained at a pharmacy for self administration:

- Obtain at MVP's specialty pharmacy (CuraScript) for office administration (*may be required*)
- Office/Hospital/ Infusion Center: Place of Service _____
- Other _____

Request for Initial Therapy:

NUMBER OF SWOLLEN OR TENDER JOINTS > 6? YES NO

DURATION OF MORNING STIFFNESS: _____(min) YES NO

HISTORY OF SEVERE OR CHRONIC ACTIVE INFECTIONS? YES NO

OTHER SYMPTOMS: _____

TB SKIN TEST RESULT: _____ DATE: _____

LIST OR PROVIDE CHART NOTES IDENTIFYING CURRENT AND PAST THERAPIES (E.G. NSAIDs, DMARDs), DOSE, DURATION OF USE AND RESPONSE. PROVIDE CONTRAINDICATIONS FOR USE OF OTHER AGENTS

DRUG NAME/DOSE	START DATE	STOP DATE	RESPONSE/COMMENTS

FOR ANKYLOSING SPONDYLITIS only:

CHEST WALL EXPANSION (cm): _____

LUMBAR FLEXION (cm): _____

OCCIPUT to WALL DISTANCE (cm): _____

BASDAI (0-10): _____

PLEASE NOTE: ALL CHART NOTES/LAB REPORTS IN REFERENCE TO THIS REQUEST MUST BE RECEIVED BEFORE A REVIEW CAN BEGIN. *REQUESTS SUBMITTED WITHOUT THIS DOCUMENTATION MAY BE DENIED.*

Refer to the MVP Formulary at www.mvphealthcare.com for those drugs that require prior authorization or are subject to quantity limits or step therapy.

FAX THIS REQUEST TO:

Commercial **1-800-376-6373**

(HMO, EPO/PPO, Option, Option Child, Option Family Healthy NY, Personal Plan, CompCare, ASO)

Medicare Part D **1-800-401-0915**

(Preferred Gold, GoldAnywhere, GoldValue, USA Care, MVP RxCare)



PRIOR AUTHORIZATION REQUEST FORM
Biologic Therapy for Inflammatory Arthritis
 (Enbrel, Humira, Kineret, Orencia, Remicade, Rituxan & Cimzia)
REQUEST FOR CONTINUATION OF THERAPY

DATE OF REQUEST: _____

MEMBER INFORMATION

NAME _____

ID# _____

BIRTHDATE _____

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PROVIDER INFORMATION

NAME _____

NPI # _____

ADDRESS _____

PHONE # _____ FAX# _____

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Drug Requested: Actemra Cimzia IV Cimzia SQ Enbrel Humira Kineret Orencia IV Orencia SQ
 Remicade Rituxan Simponi

Dose/frequency/duration of therapy: _____ **Start date:** _____

Diagnosis _____ **ICD-9 code** _____

Please check one **Initial Request** **Extension Request**

If *not* obtained at a pharmacy for self administration:

- Obtain at MVP's specialty pharmacy (CuraScript) for office administration (*may be required*)
- Office/Hospital/ Infusion Center: Place of Service _____
- Other _____

Request for Continuation of Therapy:

REDUCTION in NUMBER/EXTENT of TENDER or SWOLLEN JOINTS	YES	NO
GREATER THAN 20% IMPROVEMENT IN SYMPTOMS	YES	NO
REDUCTION in DURATION of MORNING STIFFNESS	YES	NO

LIST OR PROVIDE CHART NOTES IDENTIFYING CURRENT ADDITIONAL THERAPIES (e.g. NSAIDs, DMARDs), DOSE, DURATION OF USE AND RESPONSE

DRUG NAME/DOSE	START DATE	STOP DATE	RESPONSE/COMMENTS

PROVIDE DOCUMENTATION TO SUPPORT DISCONTINUATION OF DMARD USE SINCE PRIOR AUTHORIZATION PERIOD _____

FOR ANKYLOSING SPONDYLITIS only:

CHEST WALL EXPANSION (cm): _____ LUMBAR FLEXION (cm): _____
 OCCIPUT to WALL DISTANCE (cm): _____ BASDAI (0-10): _____

PLEASE NOTE: ALL CHART NOTES/LAB REPORTS IN REFERENCE TO THIS REQUEST MUST BE RECEIVED BEFORE A REVIEW CAN BEGIN. REQUESTS SUBMITTED WITHOUT THIS DOCUMENTATION MAY BE DENIED.

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