PRIOR AUTHORIZATION REQUEST FORM
Biologic Therapy for Inflammatory Arthritis
(Enbrel, Humira, Kineret, Orencia, Otezla, Remicade, Rituxan, Simponi, Stelara, Actemra, Xeljanz & 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.

PRESCRIBING PHYSICIAN INFORMATION

NAME ________________________________

NPI # ________________________________

ADDRESS ________________________________

____

PHONE #______________FAX#______________

CONTACT NAME ________________________

PROVIDER SIGNATURE ______________________

Drug Requested: ☐Actemra) ☐Cimzia (self-administered) ☐Enbrel ☐Humira ☐Kineret

☐Orencia (not self-administered) ☐ Orencia SQ ☐ Otezla ☐Remicade ☐Rituxan ☐ Simponi Aria

☐Simponi ☐Stelara ☐ Xeljanz

Dose/frequency/duration of therapy: ________________________________

Diagnosis_____________________ **ICD-10 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 (Caremark) to be shipped to the office for administration

☐ (Circle One) Office/Hospital/Infusion Center: Other ________________________________

☐ Facility Name ______________________________Facility NPI__________________________

Request for Initial Therapy:

NUMBER OF SWOLLEN OR TENDER JOINTS:________

DURATION OF MORNING STIFFNESS: ___________(min)

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, Exchange, Medicaid, Child Health Plus, ASO)

Medicare Part D **1-800-401-0915**
(Preferred Gold, Gold PPO, GoldValue, BasiCare, USA Care, MVP RxCare)

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(Enbrel, Humira, Kineret, Orencia, Otezla, Remicade, Rituxan, Simponi, Stelara, Actemra, Xeljanz & 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#_________________

CONTACT NAME ________________________________

PROVIDER SIGNATURE ___________________________

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☐Simponi ☐ Stelara ☐ Xeljanz ☐Kineret

Dose/frequency/duration of therapy: _________________________________**Start date:**______________________

Diagnosis_______________________________ **ICD-10 code** ____________________________

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

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

☐ Obtain at MVP's specialty pharmacy (Caremark) to be shipped to the office for administration

☐ (Circle One) Office/Hospital/Infusion Center: Other ____

☐ Facility Name ____Facility NPI______________________________

Request for Continuation of Therapy:

REDUCTION in NUMBER/EXTENT of TENDER or SWOLLEN JOINTS 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): _________________________

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Effective February 2016