Prior Authorization Request Form for Immunomodulators Enbrel/Humira/Kineret/Remicade

Member Information

Patient Name _____

Cardholder ID _____

Date of Birth _____

Address _____

City, State Zip _____

Phone Number _____

Provider Information

Provider Name _____

DEA Number _____

Address _____

City, State and Zip _____

Phone Number _____

FAX Number _____

Pharmacy Information

Pharmacy Name_____Address_____Phone_____

Drug and Strength Requesting:_____

Criteria for Approval:

1. Is the patient 18 years of age or older? Yes ☐ No ☐
2. Has the patient been on Humira/Enbrel/Kineret/Remicade for the previous six months? Yes ☐ No ☐
3. Does the patient have a diagnosis of one of the following disease states? *Check one*
   - ☐ moderate to severe rheumatoid arthritis
   - ☐ moderate to severe juvenile rheumatoid arthritis
   - ☐ active ankylosing spondylitis
   - ☐ fistulating Crohn's disease
   - ☐ psoriatic arthritis
   - ☐ chronic moderate to severe plague psoriasis
     a. is >10% of the body surface affected? Yes ☐ No ☐
     b. does the patient have an active chronic or localized infection? Yes ☐ No ☐
4. Has the patient tried and failed at least one non-steroidal anti-inflammatory NSAID? Yes ☐ No ☐
5. Has the patient tried and failed at least one disease-modifying rheumatoid antirheumatic drugs (DMARDa)? Yes ☐ No ☐
   Check all that apply: ☐Methotextrate ☐Imuran ☐Ridaura ☐Plaquenil ☐Arava ☐Cuprimine ☐Azulfidine
6. Will the patient be using Humira in combination with Kineret (anakinra), Enbrel (etanercept) or Remicade (infliximab)? Yes ☐ No ☐
7. Has the patient been tested to tuberculosis? Yes ☐ No ☐
   Test Result: Positive ☐ Negative ☐
8. Is the patient using a tumor necrosis factor (TNF) blocking agent? Yes ☐ No ☐
9. Is the patient pregnant? Yes ☐ No ☐
10. Is the patient aware of the potential risks to the fetus? Yes ☐ No ☐

Provider Signature _____ Date _____

FOX Rx Care
We take your coverage personally.

Fax completed forms to (866) 284-4509.

For Office Use Only

Date/TimeReceived_____

ReferenceNumber_____

Approved / Denied (Circle One) by_____Date_____

Date/Time Returned to Provider_____

If you have any questions regarding this form, contact the Prior Authorization Department Toll Free at (866) 284 -4492 or Fax Toll Free at (866) 284-4509.

FOX Rx Care Utilization Management
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Tallahassee, FL 32308