

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 plaque 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 _____



Fax completed forms to (866) 284-4509.

For Office Use Only

Date/Time Received _____

Reference Number _____

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
3375-I Capital Circle NE
Tallahassee, FL 32308

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