hawk-i Healthy and Well Kids in Iowa | ia health link | Amerigroup An Anthem Company

https://providers.amerigroup.com

Methotrexate Injection (Otrexup, Rasuvo)

Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-512-9004
Provider Help Desk 1-800-454-3730

1. Patient information	**2. Physician information**
Patient Name: ______________________	Prescribing Physician: ______________________
Patient ID #: ______________________	Physician Address: ______________________
Patient DOB: ______________________	Physician Phone #: ______________________
Date of Rx: ______________________	Physician Fax #: ______________________
Patient Phone #: ______________________	Physician Specialty: ______________________
Patient Email Address: ______________________	Physician DEA: ______________________
	Physician NPI #: ______________________
	Physician Email Address: ______________________

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
☐ Otrexup ☐ Rasuvo	______________	______________	Specify: ______________

7. DIAGNOSIS: ____

8. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY
NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

Severe, Active Rheumatoid Arthritis (RA) and Polyarticular Juvenile Idiopathic Arthritis (pJIA):

☐ Yes ☐ No Patient has a diagnosis of severe, active rheumatoid arthritis (RA)

☐ Yes ☐ No Patient has a diagnosis of polyarticular juvenile idiopathic arthritis (pJIA)

☐ Yes ☐ No Requested medication is prescribed by a rheumatologist

☐ Yes ☐ No Patient has a documented trial and intolerance with oral methotrexate **If No:**

- ☐ Yes ☐ No Documented evidence is provided that the use of these agents would be medically contraindicated

☐ Yes ☐ No Patient has a documented trial and therapy failure or intolerance with at least one other non-biologic DMARD (hydroxychloroquine, leflunomide, or sulfasalazine) **If No:**

- ☐ Yes ☐ No Documented evidence is provided that the use of these agents would be medically contraindicated

☐ Yes ☐ No Patient's visual or motor skills are impaired to such that they cannot accurately draw up their own preferred generic methotrexate injection and there is no caregiver available to provide assistance

☐ Yes ☐ No Patient resides in a long-term care facility

Severe, Recalcitrant, Disabling Psoriasis:

☐ Yes ☐ No Patient has a diagnosis of severe, recalcitrant, disabling psoriasis

☐ Yes ☐ No Requested medication is prescribed by a dermatologist

☐ Yes ☐ No Patient has documentation of an inadequate response to all other standard therapies (oral methotrexate, topical corticosteroids, vitamin D analogues, cyclosporine, systemic retinoids, tazarotene, and phototherapy) **If No:**

- Yes ☐ No Documented evidence is provided that the use of these agents would be medically contraindicated

PAGE 1 OF 2, CONTINUED ON PAGE 2

Patient Name: ________________________ **Patient ID#:** ________________________

☐ Yes ☐ No Patient's visual or motor skills are impaired to such that they cannot accurately draw up their own preferred generic methotrexate injection and there is no caregiver available to provide assistance

☐ Yes ☐ No Patient resides in a long-term care facility

☐ Yes ☐ No Patient is 18 years of age or older

Please Note: Documentation may include, but is not limited to, chart notes, prescription claims records, prescription receipts, and laboratory data.

9. Physician signature

________________________ ________________________
Prescriber or Authorized Signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

The document(s) accompanying this transmission may contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation.
If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.