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CONTAINS CONFIDENTIAL PATIENT INFORMATION

Rheumatrex (methotrexate)

Prior Authorization of Benefits (PAB) Form

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:__ Physician Address: __
Patient ID #: _____	_____ Physician Phone #:
Patient DOB: _____	_____ Physician Fax #: __
Date of Rx: _____	_____ Physician Specialty:
Patient Phone #: _____	_____ Physician DEA:
Patient Email Address: _____	_____ Physician NPI #: __
	_____
	Physician Email Address: _____

3. MEDICATION	4. STRENGTH	5. DIRECTIONS	6. QUANTITY PER 30 DAYS
Rheumatrex (methotrexate)	_____	_____	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.

□ Yes □ No Patient has tried methotrexate (generic)

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.

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