

**Request Form For Self Injectable Biological For Treating Arthritis
(i.e. Enbrel® or Humira®)**



Fax non-urgent requests to PerformRx Pharmacy Services at **866-369-6041** or urgent requests to **866-533-5497**. Urgent requests should be reserved for those situations in which applying the standard procedure may seriously jeopardize the enrollee's life, health, or ability to regain maximum function. To speak to a representative, call **866-369-6037**. *Form must be completed for processing.*

Patient Name: _____ Plan ID#: _____
 Address: _____ Apt # or Suite #: _____
 City: _____ State: _____ Zip Code: _____
 Phone #: _____ Weight: _____ lbs = _____ Kg Birth Date: _____

Physician Name: _____ NPI #: _____
 Address: _____ Apt # or Suite #: _____
 City: _____ State: _____ Zip Code: _____
 Contact Person: _____ Phone #: _____ Fax #: _____

Physician Signature: _____

Drug to be administered from (on): _____ to _____
 Is the member/patient currently residing in a Long-Term Care (LTC) facility? (please check) Yes No

Has the member been evaluated for active or latent TB infection? YES NO Date of PPD (tuberculin skin test): _____

Diagnosis: _____ ICD-9 Diagnosis Code: _____

Drug Name: _____ Dose: _____ Sig: _____
 Deliver to Patient's Home Deliver to Physician's Office Pick-up at Local Pharmacy (Name/Phone#): _____

For prior authorization of self injectable biologic additional information is needed to proceed with review. Please identify the therapies attempted by completing the medication chart below indicating the dose, start date, end date and reasons for discontinuation (e.g. intolerance, hypersensitivity, other medical reasons, etc). Please attach any needed applicable documentation

<input checked="" type="checkbox"/>	Drug	Dose/Sig	Start Date	End Date	Comments
<input type="checkbox"/>	Methotrexate (MTX)				
<input type="checkbox"/>	Triple Combo Therapy (Sulfasalazine, MTX, & Hydroxychloroquine)				
<input type="checkbox"/>	Leflunomide (Arava®)*				
<input type="checkbox"/>	Etanercept (Enbrel®)*				
<input type="checkbox"/>	Anakinra (Kineret®)*				
<input type="checkbox"/>	Adalimumab (Humira®)*				
<input type="checkbox"/>	Other ()				

*These medication require prior authorization

AdditionalComments: _____