PRESCRIPTION DRUG
MEDICATION REQUEST FORM
FAX TO 1-866-240-8123

Chronic Inflammatory Diseases

Member/Provider Information:

Subscriber ID Number			Group Number
Patient Name	Patient Telephone Number		Date of Birth
Patient Address	City	State	Zip Code
Physician Name	Phone		Fax
Physician Address with Suite / Building	City	State	Zip Code
NPI	Physician Signature		Date

Clinical Information:

Medication Requested: _____ Dose and Quantity Requested: _____

Is this a request for reauthorization? Yes / No Does the patient require induction dosing? Yes / No

Documentation of Medical Necessity:

1. Please provide the patient's diagnosis or ICD-10 code_____

2. Has the patient experienced therapeutic failure to any of the following therapies? Please select **ALL** that apply
   - ☐ Methotrexate
   - ☐ Cyclosporine
   - ☐ Azathioprine
   - ☐ Mercaptopurine
   - ☐ Leflunomide
   - ☐ Hydroxychloroquine
   - ☐ An NSAID (e.g., ibuprofen)
   - ☐ A systemic corticosteroid (e.g., prednisone)
   - ☐ Sulfasalazine
   - ☐ Phototherapy (e.g., PUVA, UVB)
   - ☐ A local glucocorticoid injection
   - ☐ Other _____

3. Has the patient experienced therapeutic failure to any of the following biologic medications? Please select **ALL** that apply
   - ☐ Actemra
   - ☐ Entyvio
   - ☐ Olumiant
   - ☐ Siliq
   - ☐ Taltz
   - ☐ Cimzia
   - ☐ Humira
   - ☐ Orencia
   - ☐ Simponi
   - ☐ Tremfya
   - ☐ Cosentyx
   - ☐ Kevzara
   - ☐ Otezla
   - ☐ Skyrizi
   - ☐ Xeljanz
   - ☐ Enbrel
   - ☐ Kineret
   - ☐ Remicade
   - ☐ Stelara
   - ☐ Other _____

4. If this request is for **reauthorization**, is there clinical documentation of disease stability or improvement while on this medication?
   - ☐ Yes
   - ☐ No

5. Please provide any additional information pertinent to this request: _____
   _____
   _____
   _____

6. If requesting Stelara, please provide the patient's weight _____

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.