HIGHMARK | HIGHMARK

Medication Prior Authorization Form

Fax to 1-866-240-8123

Chronic Inflammatory Diseases

Member Information:

Subscriber's ID Number			Subscriber's Group Number
Member's Name		Phone	Date of Birth
Address	City	State	Zip Code

Provider Information:

Physician's Name	NPI	Phone	Fax
Address	City	State	Zip Code
Suite / Building	Physician's Signature		Date

Medication Information:

Drug Name	Drug Strength	Requested Quantity	Requested Day Supply ☐ 30 days ☐ 90 days ☐ Other: _____
Directions			
Diagnosis and/or ICD-10 code(s)			
1. Does the member require induction dosing?		Yes	No
2. Is the member currently on therapy with the requested medication?		Yes	No
If **YES**:			
2a. Is there clinical documentation of disease stability or improvement while on this medication?		Yes	No

Clinical Information:

1. The requested medication is being prescribed by, or in consultation, with a:

   ☐ Rheumatologist ☐ Dermatologist

   ☐ Ophthalmologist ☐ Geneticist

   ☐ Gastroenterologist ☐ Allergist

   ☐ Immunologist ☐ Pulmonologist

   ☐ Physician specializing in the treatment of autoinflammatory disorders

   ☐ Other: _____

2. Has the member experienced therapeutic failure to any of the following therapies?
   Please select **ALL** that apply:

   ☐ Methotrexate ☐ Leflunomide ☐ Sulfasalazine
   ☐ Cyclosporine ☐ Hydroxychloroquine ☐ Phototherapy (e.g., PUVA, UVB)
   ☐ Azathioprine ☐ An NSAID (e.g., ibuprofen) ☐ A local glucocorticoid injection
   ☐ Mercaptopurine ☐ A systemic corticosteroid (e.g., prednisone)

   ☐ Other(s): _____

   _____

3. Please provide the member's weight and include the unit of measure (for example, lb or kg):

   _____

4. Please provide any additional information pertinent to this request:

   _____

   _____

   _____

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

INSTRUCTIONS FOR COMPLETING THIS FORM

1. Submit a separate form for each medication.
2. Please print, type or write legibly in blue or black ink.
3. Complete **ALL** information on the form.
   NOTE: *The prescribing physician (PCP or Specialist) should, in most cases, complete the form.*
4. Please provide the physician address as it is required for physician notification.
5. Fax the **completed** form and all clinical documentation to **1-866-240-8123**
   Or mail the form to: **120 Fifth Avenue, SPECARE, Pittsburgh, PA 15222**

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