



# BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association.

## RHEUMATOID ARTHRITIS, ANKYLOSING SPONDYLITIS, PSORIASIS AND PSORIATIC ARTHRITIS COVERAGE AUTHORIZATION REQUEST FORM

This form is for authorization of prescription drug benefits only and must be COMPLETELY filled out.

### GENERAL INFORMATION *Request Type ( please check one)*

Prior Authorization     Step Therapy Exception     Appeal     Quantity Limit Exception

Patient Name	Date of Birth (mm/dd/yyyy) <table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>										

Patient's Home Address	Contract Number (include prefix) <table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>																				

City	State	Zip	
------	-------	-----	--

### PHYSICIAN INFORMATION

Physician Name	Practice Type <input type="checkbox"/> PCP <input type="checkbox"/> Specialty: _____
----------------	---

Practice Address	Physician NPI <table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>																				

City	State	Zip	Provider Number <table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>																				

Office Phone	Office Fax	
--------------	------------	--

### TREATMENT INFORMATION

**Drug Requested:**     Enbrel®     Humira®     Kineret®     Cimzia®     Simponi™    Dosage: \_\_\_\_\_

**Disease State:**     Rheumatoid Arthritis     Ankylosing Spondylitis     Crohn's Disease  
 Juvenile Idiopathic Arthritis     Psoriatic Arthritis     Psoriasis

**Severity of Disease:**     Mild to Moderate     Moderate to Severe     Severe    **Duration of Disease :** \_\_\_\_\_

**List the most recent SYSTEMIC Medications this Patient has tried; DO NOT LIST Topicals**

Drug: _____	Regimen: _____	Dates of Therapy: _____ to _____
Drug: _____	Regimen: _____	Dates of Therapy: _____ to _____
Drug: _____	Regimen: _____	Dates of Therapy: _____ to _____
Drug: _____	Regimen: _____	Dates of Therapy: _____ to _____

**Has this Patient tried Phototherapy?**     Yes     No    **If so, for how long?** \_\_\_\_\_

**Does this patient have any contraindications to DMARD therapy?**     Yes     No    **If so, please list:** \_\_\_\_\_

I certify this information is complete and correct to the best of my knowledge.

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date

### SUBMISSION INSTRUCTIONS

**FAX**

You may fax the signed and completed form to Pharmacy Review at: **866 606-6021**

**MAIL**

You may mail the signed and completed form to: **Pharmacy Review Post Office Box 3210 Auburn, AL 36831**