



Rheumatoid Arthritis

(Enbrel, Humira, Cimzia, Kineret, Orencia SQ, Xeljanz, Actemra and Simponi)

Beneficiary Information

- 1. Beneficiary Last Name: 2. First Name: 3. Beneficiary ID #: 4. Beneficiary Date of Birth: 5. Recipient Gender:

Prescriber Information

- 6. Prescribing Provider NPI#: 7. Requester Contact Information - Name: Phone #: Ext:

Drug Information

- 8. Med requested: 9a. Strength 9b. Quantity per 30 days 9c. Duration

10. Does the beneficiary have a diagnosis of Rheumatoid Arthritis? YES NO

11. Is the beneficiary on any other injectable immunomodulator? YES NO

12. Has the beneficiary been screened for latent tuberculosis infection? YES NO

13. Has the beneficiary been tested with Hep B SAG and Core Ab? YES NO Date of lab and result

14. Has the beneficiary experienced a therapeutic failure/inadequate response with methotrexate or at least one disease modifying antirheumatic drug (e.g. leflunomide, hydroxychloroquine, minocycline, sulfasalazine)?

YES NO

15. Is the beneficiary unable to take methotrexate or at least one disease modifying antirheumatic drug due to contraindications or intolerabilities?

YES NO Explain

16. Does the beneficiary have clinical evidence of severe or rapidly progressing disease? YES NO

17. If requesting a non-preferred, list preferred tried or reason beneficiary cannot use the preferred.

Signature of Prescriber: Date:

(Prescriber signature mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: (800) 678-3189 Pharmacy PA Call Center: (866) 799-5318