

**Request Form For Self Injectable Biological For Treating Arthritis
(Enbrel®, Kineret®, and Humira®)**



Non-Urgent Requests: Fax to (866) 369-6038

Urgent Requests: Fax to (866) 533-5491

To speak to a PerformRx representative: Call (866) 533-5490

Note: Urgent requests should be reserved for those situations in which applying the standard procedure may seriously jeopardize the member's life, health, or ability to regain maximum functions.

Form must be completed for processing.

Member Name: _____	Member ID#: _____
Address: _____	Apt # or Suite #: _____
City: _____ State: _____	Zip Code: _____
Phone #: _____ Height: _____ Weight: _____ lbs = _____ Kg	Birth Date: _____
Provider Name: _____	NPI/License #: _____
Address: _____	Apt # or Suite #: _____
City: _____ State: _____	Zip Code: _____
Contact Person: _____ Phone #: _____	Fax #: _____ E Mail: _____

Is the member currently residing in a Long-Term Care (LTC) facility? (please check) Yes No

Drug to be administered from (on): _____ to _____

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

Drug Name: _____ Dose: _____ Sig: _____

Deliver to: Member's Home Provider's Office Member Filling at Local Pharmacy (Name): _____ Telephone: _____

For coverage determination of self-injectable biologic (e.g. Enbrel, Kineret, Humira) to treat Rheumatoid or Psoriatic Arthritis, additional information is needed to proceed with review. Prior to receiving approval for therapy, the patient must have a documented medical reason to being unable to take oral therapeutic medications (see the table below of therapeutic alternatives). 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).

✓	Drug	Dose	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 medications require coverage determination and will only be approved when the member has a medical reason for not taking the above oral therapeutic medications.

Additional Comments: _____