

Pharmacy Request for Prior Approval – Ankylosing Spondylitis

(Avsola, Cimzia, Cosentyx, Enbrel, Humira, Inflectra, Remicade,
Renflexis, Simponi, Simponi Aria and Taltz)

Beneficiary Information

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

Prescriber Information

6. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
7. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy: ___up to 30 days ___60 days ___90 days ___120 days ___180 days ___365 days ___Other: _____

Clinical Information

1. Does the beneficiary have a diagnosis of Ankylosing Spondylitis? Yes___ No___
2. Is the beneficiary on any other injectable immunomodulator? Yes___ No___
3. Has the beneficiary been screened for latent tuberculosis infection? Yes___ No___
4. Has the beneficiary been tested with Hep B SAG and Core Ab? Yes___ No___
5. Has the beneficiary experienced inadequate symptom relief from treatment with at least two (2) NSAIDs? Yes___ No___
Please List NSAIDs used: _____
6. Is the beneficiary unable to use NSAIDs? Yes___ No___
Please Explain: _____

7. Does the beneficiary have clinical evidence of severe or rapidly progressing disease? Yes___ No___
Please Explain: _____

8. Has the beneficiary tried and failed Cosentyx, Enbrel or Humira? Yes___ No___
If No, Please provide the clinical reason why the beneficiary has not tried Cosentyx, Enbrel or Humira: _____

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: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406