BlueCross BlueShield of Alabama

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RHEUMATOID ARTHRITIS, ANKYLOSING SPONDYLITIS, PSORIASIS AND PSORIATIC ARTHITIS 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)
Patient's Home Address	Contract Number (include prefix)
City / State / Zip	

PHYSICIAN INFORMATION

Physician Name	Practice Type ☐ PCP ☐ Specialty: _____
Practice Address	Physician NPI
City / State / Zip	Provider Number
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 _____
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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