

Please note: All information below is required to process this request.

Fax to 1-844-403-1029

Mon-Sat: 7am to 7pm Central

Otrexup® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)				Provider Information (required)		
Member Name:			Provider Name:	Provider Name:		
Insurance ID#:			NPI#:		Specialty:	
Date of Birth:			Office Phone:	Office Phone:		
Street Address:			Office Fax:	Office Fax:		
City:	State:	Zip:	Office Street Ad	Office Street Address:		
Phone:			City:	State:	Zip:	
		Medication	Information (req	uired)		
Medication Name:			Strength:	·	Dosage Form:	
☐ Check if requesting brand			Directions for U	se:		
☐ Check if request is for continuation of therapy						
		Clinical In	formation (require	ed)		
Select the diagnos	sis below:		· ·	,		
☐ Active polyarticular juvenile idiopathic arthritis (pJIA)						
☐ Severe, active r	-	., ,				
☐ Severe, recalcit	rant, disabling p	soriasis				
Other diagnosis: ICD-10 Code(s):						
For active polyart following:	icular juvenile i	diopathic arthritis (p.	JIA) or severe, active	rheumatoid a	rthritis (RA), answer the	
Is the patient intole	rant of or has ha	d an inadequate respo	nse to first-line therap	y? 🗆 Yes 📵 🛭	No	
Has the patient trie 180 days? ☐ Yes		month of a standard d	osage form of methotr	exate (e.g., ora	ıl, injectable) within the last	
For severe, recalc	itrant, disablin	g psoriasis, answer th	ne following:			
Has the patient had inadequate response to other forms of therapy? Yes No						
Has the patient trie 180 days? ☐ Yes		month of a standard d	osage form of methotr	exate (e.g., ora	ıl, injectable) within the last	
Are there any other co	omments, diagnose	es, symptoms, medications	s tried or failed, and/or any	y other informatio	n the physician feels is important to	
		enied unless all required info d requests please call 1-855-				
		for non-urgent requests and				

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