PRIOR AUTHORIZATION FORM
DUR Medication
OTREXUP™ (methotrexate subcutaneous injection)

Anthem HealthKeepers
Offered by HealthKeepers, Inc.

Requests for prior authorization (PA) must include patient name, Medicaid ID # and drug name. Appropriate clinical information to support the request on the basis of medical necessity must be submitted. Please include all requested information; incomplete forms will delay the PA process.

The completed form may be faxed to **1-844-512-7022 for Medical Injectables.**

Today's Date: ___ ___/___ ___/___ ___ ___ ___ Requested Start Date: ___ ___/___ ___/___ ___ ___ ___

PATIENT INFORMATION

Name: (Last, First) _____ **Medicaid ID#:** ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ __

Date of Birth: ___ ___/___ ___/___ ___ ___ ___ **Gender:** □ **Male** □ **Female**

DRUG INFORMATION

Drug Name/ Form: _____ **Strength:** _____
Dosing Frequency: _____ **Length of Therapy:** _____
Quantity per day: _____

DIAGNOSIS AND MEDICAL INFORMATION – Please Answer All Questions To Facilitate Processing

OTREXUP™- to receive a one (1) year PA for this drug, please complete the questions below.

Does the patient meet the following criteria?

- Diagnosis of active rheumatoid arthritis (RA) or polyarticular juvenile idiopathic arthritis (pJIA) □ Yes □ No
- Therapeutic failure to oral methotrexate? □ Yes □ No
- Patient does not require any of the following methotrexate regimens □ Yes □ No
  - Doses less than 10 mg per week,
  - Doses above 25 mg per week,
  - High dose regimens, or
  - Dose adjustments less than 5 mg increments

Medical necessity: Provide clinical evidence that support the use of the requested medication.

PRESCRIBER INFORMATION

Name/Specialty (print):_____ NPI Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Phone Number: (___ ___ ___) ___ ___ ___-___ ___ ___ ___ Fax Number: (___ ___ ___) ___ ___ ___-___ ___ ___ ___

Signature of Prescribing Provider: _____

PLEASE INCLUDE ALL REQUESTED INFORMATION
INCOMPLETE FORMS WILL DELAY THE PRIOR AUTHORIZATION PROCESS

FAX TO 1-844-512-7022 for Medical Injectables.
PRIOR AUTHORIZATION CRITERIA IS SUBJECT TO CHANGE AND THUS DRUG COVERAGE.