Prior Authorization Form

CAREMARK FAX FORM

Arava

This fax machine is located in a secure location as required by HIPAA regulations.
Complete information, sign and date. Fax completed forms to Caremark at 1-888-836-0730

Please contact Caremark @ 1-888-414-3125 with questions regarding the prior authorization process.

When conditions are met, we will authorize the coverage of Arava

Drug Name: _____

Patient:
Patient Name: _____
Patient ID: _____
Patient Group Number: _____
Patient Date Of Birth: _____

Prescribing Physician:

Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician _____
Physician City, State, Zip: _____

Diagnosis: **ICD 9 code:**

Please circle the appropriate answer for each applicable question.

1	Does the patient have a diagnosis of rheumatoid arthritis?	Y	N
	[If the answer to the question is no, may skip to question 7.]		
2	Has the patient been receiving Arava for at least 6 months?	Y	N
	[If the answer to the question is no, may skip to question 4.]		
3	Have the patient`s arthritis symptoms improved since initiation of therapy?	Y	N
	[Skip to question 11.]		
4	Is the patient a female of child-bearing potential?	Y	N
	[If the answer to the question is no, may skip to question 11.]		
5	Has pregnancy been excluded as confirmed by a negative urine or serum pregnancy test?	Y	N
6	Has the patient been counseled on the potential serious fetal risks?	Y	N
	[Skip to question 11.]		
7	Does the patient have a diagnosis of psoriatic arthritis?	Y	N
8	Is the patient a female of child-bearing potential?	Y	N
	[If the answer to the question is no, may skip to question 11.]		
9	Has pregnancy been excluded as confirmed by a negative urine or serum pregnancy test?	Y	N
10	Has the patient been counseled on the potential serious fetal risks?	Y	N
11	Does the patient have a medical history of significant hepatic impairment (aminotransferase levels greater than 300 U/L) or was the patient tested for evidence of active Hepatitis B or C infection and had positive results?	Y	N

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12	Will the patient have an ALT (liver function test) done prior to beginning Arava therapy and repeated monthly for the first 6 months, and then at least every 6 to 8 weeks during therapy?	Y	N
13	Will the patient have platelet and white cell counts and hematocrit and/or hemoglobin done prior to beginning Arava and repeated monthly for the first 6 months, and then at least every 6 to 8 weeks during therapy?	Y	N

Comments: _____

Information given on this form is accurate as of this date.

_____

Prescriber or Authorized Signature