BlueCross BlueShield Federal Employee Program

METHOTREXATE INJECTIONS PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Methotrexate Injections

NOTE: Form must be completed in its **entirety** for processing

Please select medication: ❑**Otrexup** ❑**Rasuvo** ❑**RediTrex**

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

Is this request for brand or generic? ❑Brand ❑Generic

1. Has the patient been on this medication continuously for the last **6 months**, excluding samples? ***Please select answer below:***

❑**NO** – this is **INITATION** of therapy, please answer the following questions:

a. What is the patient's diagnosis?

❑Polyarticular Juvenile Idiopathic Arthritis (pJIA)

i. Does the patient have active polyarticular juvenile idiopathic arthritis? ❑Yes ❑No

ii. Does the patient have a contraindication or have they had an inadequate response or intolerance to NSAIDs, and oral methotrexate? ❑Yes ❑No

❑Psoriasis (PsO)

i. Does the patient have active psoriasis? ❑Yes ❑No

ii. Does the patient have a contraindication or have they had either an inadequate response or intolerance to NSAIDs, topical corticosteroids and oral methotrexate? ❑Yes ❑No

❑Rheumatoid Arthritis (RA)

i. Does the patient have severely active rheumatoid arthritis? ❑Yes ❑No

ii. Does the patient have a contraindication or have they had an inadequate response intolerance to NSAIDs, and oral methotrexate? ❑Yes ❑No

❑Other diagnosis ***(please specify)***: _____

b. Is there a documented reason for requiring a special injection device? ❑Yes***** ***(*If YES, select reason below)*** ❑No

❑Lack of dexterity ❑Visual acuity issues ❑Other ***(please specify):*** _____

❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:

a. What is the patient's diagnosis?

❑Polyarticular Juvenile Idiopathic Arthritis (JIA) ❑Psoriasis (PsO) ❑Rheumatoid Arthritis (RA)

❑Other diagnosis ***(please specify)***: _____

b. Has the patient's condition improved or stabilized with therapy? ❑Yes ❑No

2. **FEMALE Patient**: Is the patient of reproductive potential? ❑Yes***** ❑No

If YES, has the patient had a negative pregnancy test prior to initiating therapy? ❑Yes***** ***(*If YES, answer question below)*** ❑No

a. **Otrexup or Reditrex Request:** Will the patient be advised to use effective contraception during treatment with this medication and for six months after the final dose? ❑Yes ❑No

Rasuvo Request: Will the patient be advised to use effective contraception during treatment with Rasuvo and for at least one ovulatory cycle after the final dose? ❑Yes ❑No

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL QUESTIONS

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer.

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PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ **DOB:** _____ **Patient ID: R** _____

MALE Patient: Does the patient have a female partner of reproductive potential? ❑Yes***** ❑No

If YES, will the patient be advised to use effective contraception during treatment with this medication and for three months after the final dose? ❑Yes ❑No

3. Does the prescriber agree to comply with regular monitoring of blood counts, renal function, and hepatic function testing? ❑Yes ❑No

4. Will this medication be used in combination with another form or brand of methotrexate? ❑Yes***** ❑No

If YES, specify the medication: _____

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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug Prior Authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727**. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer.