Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Anti-Arthritic -Folate Antagonist Agents Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 6 months; Continuation- 12 months (6 mo for PsO)

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Anti-Arthritic -Folate Antagonist Agents** methotrexate (Otrexup & Rasuvo)**.** Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: 1-866-331-2104]. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless this form is complete. The KP-MAS Formulary can be found at:** Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Provider Information

Provider Name: _____ Specialty: _____ Provider NPI: _____

Provider Address: _____

Provider Phone #: _____Provider Fax #: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____

5– Diagnosis/Clinical Criteria

Clinical Criteria:

1. Does the member have diagnosis of one of the following? **AND**
   □ Rheumatoid Arthritis (RA)

□ Plaque Psoriasis (PsO)

□ Polyarticular juvenile idiopathic arthritis (pJIA)

□ Other: _____

2. Does the patient have allergy or contraindication to benzoyl alcohol or other preservative contained in generic injectable ? **AND**

   □ No □ Yes

3. If this is being used for Rheumatoid Arthritis (RA):
   a. Has had therapeutic failure to two preferred DMARD agents?
      □ No □ Yes

4. If this is being used for Polyarticular juvenile idiopathic arthritis (pJIA):
   a. Has had therapeutic failure to two preferred NSAIDS agents?
      □ No □ Yes

5. If this is being used for Psoriasis:
   a. Was there therapeutic failure on a topical psoriasis agent (emollients and/or topical corticosteroids, topical retinoids, topical vitamin D analogs, and topical tacrolimus AND pimecrolimus)?
      □ No □ Yes

If "no" to any of the above, provide explanation: _____

For continuation of therapy, please respond to additional questions below:
Is the patient followed by a physician for monitoring of renal and hepatic function and complete blood counts with differential and platelet count?

□ No □ Yes

6 – Provider Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____
_____
_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Provider Signature:	**Date:**