



Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Methotrexate (Rasuvo, Otrexup) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 12 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **methotrexate (Rasuvo, Otrexup)**. Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: [1-866-331-2104](tel:1-866-331-2104)]. If you have any questions or concerns, please call [1-866-331-2103](tel:1-866-331-2103). **Requests will not be considered unless this form is complete. The KP-MAS Formulary can be found at: <http://pithelp.appl.kp.org/MAS/formulary.html>**

1 – Patient Information

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

2 – Prescriber Information

Is the prescriber a rheumatologist or dermatologist? No Yes

If consulted with a specialist, specialist name and specialty: _____

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____ Prescriber Fax #: _____

Please check the boxes that apply:

Initial Request Continuation of Therapy Request

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

Initial Therapy:

1. Does the member have a diagnosis of adult with severe, active rheumatoid arthritis? **AND**
 No Yes
2. Did the member try and have an inadequate response or intolerance to generic oral methotrexate? **AND**
 No Yes
3. Is the patient unable to prepare and administer generic injectable methotrexate? **OR**
 No Yes
4. Does the member have a diagnosis of child with active polyarticular juvenile idiopathic arthritis? **AND**
 No Yes
5. Did the patient try and have an inadequate response or intolerance to generic oral methotrexate? **AND**
 No Yes
6. Is the patient unable to prepare and administer generic injectable methotrexate?
 No Yes

Continuation of Therapy:

1. Does the member have a documentation of a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition? **AND**
 No Yes
2. Does the member continue to be unable to prepare and administer generic injectable methotrexate?
 No Yes

6 – Prescriber Sign-Off

Additional Information – Please provide any additional information that should be taken into consideration: _____

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

Prescriber Signature:

Date:

Please Note: This document contains confidential information, including protected health information, intended for a specific individual and purpose. The information is private and legally protected by law, including HIPAA. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any action in reliance on the contents of this telecopied information is strictly prohibited. Please notify sender if document was not intended for receipt by your facility