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]. 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: 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:**