

If the following information is not complete, correct, or legible, the SA process can be delayed.

Please use one form per member.

**MEMBER INFORMATION**

Member's Last Name:

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Member's First Name:

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MCC VA ID Number:

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Date of Birth:

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Gender:  Male  Female

Weight in Kilograms: \_\_\_\_\_

**PRESCRIBER INFORMATION**

Prescriber's Last Name:

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Prescriber's First Name:

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NPI Number:

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Specialty:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Phone Number:

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Fax Number:

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**DRUG INFORMATION**

Drug Name/Form: \_\_\_\_\_

Strength: \_\_\_\_\_

Dosing Frequency: \_\_\_\_\_

Length of Therapy: \_\_\_\_\_

Quantity per Day: \_\_\_\_\_

(Form continued on next page.)

Member's Last Name:

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Member's First Name:

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**DIAGNOSIS AND MEDICAL INFORMATION**

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Otrexup™ or Rasuvo® SA, please complete the following questions.

Length of Authorization: 6 months, renew for 1 year for RA, if compliant and appropriate monitoring occurs.  
 Approve for 6 months for psoriasis.

1. **Diagnosis of Active Rheumatoid Arthritis (RA):**

Yes       No

2. Has had therapeutic failure to two preferred DMARD agents; **AND**

Yes       No

3. Must have allergy or contraindication to benzoyl alcohol or other preservative contained in generic injectable methotrexate.

Yes       No

4. **Diagnosis of polyarticular juvenile idiopathic arthritis (pJIA):**

Yes       No

5. Has had therapeutic failure to two preferred NSAIDS agents; **AND**

Yes       No

6. Must have allergy or contraindication to benzoyl alcohol or other preservative contained in generic injectable methotrexate.

Yes       No

7. **Diagnosis of Psoriasis:**

Yes       No

8. A therapeutic trial and failure on topical therapies such as topical emollients and/or topical corticosteroids, topical retinoids, topical vitamin D analogs, and topical tacrolimus and pimecrolimus; **AND**

Yes       No

9. Must have allergy or contraindication to benzoyl alcohol or other preservative contained in generic injectable methotrexate.

Yes       No

*(Form continued on next page.)*

Member's Last Name:

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Member's First Name:

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10. **Medical Necessity:** Provide clinical evidence below that the preferred agent(s) will not provide adequate benefit.

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**Prescriber Signature (Required)**

**Date**

*By signature, the Physician confirms the above information is accurate and verifiable by member records.*

**Please include ALL requested information; Incomplete forms will delay the SA process.** Submission of documentation does NOT guarantee coverage by Magellan Complete Care of Virginia.

The completed form may be **FAXED TO 1-800-922-3986** or mailed to:

Magellan Rx Management Prior Authorization Program  
c/o Magellan Health, Inc.  
11013 West Broad Street  
Glen Allen, VA 23060

**Phone:** 1-800-424-4524 (TTY 711)