

Service Authorization (SA) Form
Otrexup™ or Rasuvo®
(methotrexate subcutaneous injection)

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:

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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

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.

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 – Medallion 4.0.

The completed form may be **FAXED TO 1-800-424-7581** or mailed to:

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

Phone: 1-800-424-4518 (TTY 711)