FAX Completed Form To
1.833.404.2392
Pharmacy Help Desk
1.800.460.8988
Prescriber Help Desk
1.833.587.2012

Request for Prior Authorization
METHOTREXATE INJECTION

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is required for non-preferred methotrexate injection. Payment will be considered under the following conditions: Patient's visual or motor skills are impaired to such that they cannot accurately draw up their own preferred generic methotrexate injection and there is no caregiver available to provide assistance in addition to: 1) Diagnosis of severe, active rheumatoid arthritis or polyarticular juvenile idiopathic arthritis and ALL of the following: a) Prescribed by a rheumatologist; and b) Patient has documented trial and intolerance with oral methotrexate; and c) Patient has documented trial and therapy failure or intolerance with at least one other non-biologic DMARD; or 2) Diagnosis of severe, recalcitrant, disabling psoriasis and ALL of the following: a) Patient is 18 years of age or older; and b) Prescribed by a dermatologist; and c) Patient has documentation of an inadequate response to all other standard therapies (oral methotrexate, topical corticosteroids, vitamin D analogues, cyclosporine, systemic retinoids, tazarotene, and phototherapy). The required trials may be overridden when documented evidence is provided that use of these agents would be medially contraindicated.

Non-Preferred

☐ Otrexup ☐ Rasuvo ☐ Reditrex

Strength	Dosage Instructions	Quantity	Days Supply

Diagnosis (additional criteria below): _____

Limitations to use of a preferred generic methotrexate injection:

What visual or physical conditions limit the patient's ability to prepare their own injections? _____

_____

Does the patient lack capable assistance residing with them? ☐ Yes ☐ No

Does the patient reside in a long-term care facility? ☐ Yes ☐ No

☐ **Severe, active rheumatoid arthritis (RA) or polyarticular juvenile idopathic arthritis (pJIA):**

Prescriber Specialty: ☐ Rheumatologist ☐ Other _____

Intolerance with oral methotrexate:

Dose: _____ Trial dates: _____

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Specific Intolerance: _____

Treatment failure with one other non-biologic DMARD (hydroxychloroquine, leflunomide, or sulfasalazine):

Drug name & dose: _____ Trial dates: _____

Reason for failure: _____

☐ **Severe, recalcitrant disabling psoriasis (Patient must be 18 years of age or older):**

Prescriber Specialty: ☐ Dermatologist ☐ Other _____

Treatment failure with all standard therapies (include trial dates, dose & failure reason for each):

☐ Oral methotrexate: _____

☐ Topical corticosteroids: _____

☐ Vitamin D analogues: _____

☐ Cyclosporine: _____

☐ Systemic retinoids: _____

☐ Tazarotene: _____

☐ Phototherapy: _____

Possible drug interactions/conflicting drug therapies: _____

_____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*