Pharmacy Prior Authorization

AETNA BETTER HEALTH FLORIDA

Rasuvo

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Florida at **1-855-799-2554**.
When conditions are met, we will authorize the coverage of Rasuvo.
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(please circle)*

Rasuvo (methotrexate auto-injector)

Other, please specify_____

Quantity _____ Frequency _____ Strength _____

Route of Administration _____ Expected Length of therapy _____

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone: _____

Prescribing Physician

Physician Name: _____

Specialty: _____ NPI Number: _____

Physician Fax: _____ Physician Phone: _____

Physician Address: _____ City, State, Zip: _____

Diagnosis:_____ ICD Code:_____

Please circle the appropriate answer for each question.

1. Is the patient 18 years of age or older? Y N
   [If no, skip to question 6.]
2. Does the patient have active rheumatoid arthritis? Y N
   [If yes, skip to question 8.]
3. Does the patient have a diagnosis of severe, recalcitrant disabling psoriasis? Y N
   [If no, no further questions.]

4. Has the patient had an inadequate response to or is the patient not a candidate for a 3-month minimum trial of phototherapy (e.g., Psoralens with UVA light (PUVA) OR UVB with coal tar or dithranol?
   [If no, no further questions.] Y N

5. Has the patient had an inadequate response, intolerance, or contraindication to all of the following: 1) methotrexate tablets and 2) methotrexate intramuscular injections? If yes, clinical documentation must be submitted demonstrating response to previous therapies.
   [No further questions.] Y N

6. Is the patient 2 years of age or older?
   [If no, no further questions.] Y N

7. Does the patient have a diagnosis of juvenile idiopathic arthritis?
   [If no, no further questions.] Y N

8. Has the patient had an inadequate response, intolerance, or contraindication to all of the following: 1) NSAIDs, 2) methotrexate tablets and 3) methotrexate intramuscular injections?
   If yes, clinical documentation must be submitted demonstrating response to previous therapies. Y N

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature Date