

Drug Coverage Review Request

Arava[®]



SUPPLY ALL PRESCRIBER AND PATIENT INFORMATION

PATIENT

MD First Name _____
MD Last Name _____
Address _____
City _____
State _____
Zip Code _____
Phone _____
Fax _____
DEA number (optional) _____

PATIENT

Cardholder ID # _____
Patient Last Name _____
Patient First Name _____
Date of Birth _____
Address _____
City _____
State _____
Zip Code _____
Phone _____

Your patient's benefit plan requires that we review certain requests for coverage with the prescribing physician. This includes requests for benefit coverage beyond plan specifications. Please complete the following questions and then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the benefit plan's rules.

SECTION A Please answer the following questions

- For which indication is this drug being prescribed? (please choose one primary indication)
 - Moderate to severe rheumatoid arthritis (RA) *^ please answer questions 2-4*
 - Treatment of established viremia due to BK virus after an initial trial of reduced immunosuppression therapy
 - Other

Questions 2-4 apply only if diagnosis is **moderate to severe rheumatoid arthritis (RA)**

- Yes No Is the patient CURRENTLY RECEIVING methotrexate?
- Yes No Has therapy with methotrexate FAILED TO TREAT the patient's condition?
- Yes No Is the patient a CANDIDATE FOR RECEIVING methotrexate?

SECTION B Physician Signature

PHYSICIAN SIGNATURE

DATE

FAX COMPLETED FORM TO: 1 800 837-0959

PLEASE DO NOT FAX WITH A COVER SHEET



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