



**Phone: 800-842-2015 Fax: 877-837-5922**

<b>PATIENT DATA</b>	Last Name	First Name	Policy Number	Date of Birth	Age
<b>REQUESTING PHYSICIAN DATA</b>	Last Name	First Name	Contact Name	Fax Number ( )	
BCBSLA Provider Number	Area of Practice/Specialty	Name of Place of Treatment	Treatment Center Provider #	Phone Number ( )	
<b>BILLING DATA</b>	Diagnosis Code(s) (ICD-9): 1) 2)		CPT-4/HCPCS Code	Other Codes	

**DRUG INFORMATION**

<input type="checkbox"/> AMEVIVE®	<input type="checkbox"/> HUMIRA®	<input type="checkbox"/> TYSABRI®	Dosage and Frequency: _____	Anticipated Start Date
<input type="checkbox"/> CIMZIA®	<input type="checkbox"/> ORENCIA®	<input type="checkbox"/> SIMPONI®		
<input type="checkbox"/> ENBREL®	<input type="checkbox"/> REMICADE®	<input type="checkbox"/> STELARA®		
<input type="checkbox"/> OTHER:				

**INDICATION / DIAGNOSIS**

<input type="checkbox"/> Ankylosing Spondylitis	<input type="checkbox"/> Moderate to Severe Active Crohn's	<input type="checkbox"/> Juvenile Idiopathic Arthritis
<input type="checkbox"/> Moderate to Severe Active Rheumatoid Arthritis	<input type="checkbox"/> Moderate to Severe Crohn's Including Fistulizing Crohn's	<input type="checkbox"/> Juvenile Rheumatoid Arthritis
<input type="checkbox"/> Plaque Psoriasis	<input type="checkbox"/> Relapsing Multiple Sclerosis	<input type="checkbox"/> Psoriatic Arthritis
<input type="checkbox"/> Moderate to Severe Chronic Plaque Psoriasis	<input type="checkbox"/> Moderate to Severe Ulcerative Colitis	<input type="checkbox"/> Other Indication: _____

**PAST TREATMENT HISTORY (Check ALL that apply)**

<input type="checkbox"/> NSAIDs (List)  <input type="checkbox"/> Methotrexate <input type="checkbox"/> Arava <input type="checkbox"/> Aurolate <input type="checkbox"/> Cuprimine <input type="checkbox"/> Imuran <input type="checkbox"/> Azathioprine <input type="checkbox"/> Corticosteroids <input type="checkbox"/> UVB	<input type="checkbox"/> Psoralen Pos UVA <input type="checkbox"/> Narrowband UVB <input type="checkbox"/> Oxsoalene Ultra <input type="checkbox"/> 8-MOP (oral methoxasalen plus UVA light (PUVA) <input type="checkbox"/> Cyclosporine <input type="checkbox"/> Sandimmune <input type="checkbox"/> Neoral <input type="checkbox"/> Soriatane	<input type="checkbox"/> Solganal <input type="checkbox"/> Plaquenil <input type="checkbox"/> Avonex <input type="checkbox"/> Betaseron <input type="checkbox"/> Copaxone <input type="checkbox"/> Rebif <input type="checkbox"/> Oral Budesonide <input type="checkbox"/> Prednisone <input type="checkbox"/> Aminosaliclylates <input type="checkbox"/> Azulfadine	<input type="checkbox"/> Mesalamine <input type="checkbox"/> Sulfasalazine <input type="checkbox"/> Balsulazide <input type="checkbox"/> Myochristine <input type="checkbox"/> Ridaura <input type="checkbox"/> 6-mercaptopurine (6-MP) <input type="checkbox"/> Mylocel <input type="checkbox"/> Hydrea <input type="checkbox"/> Other(s): _____
--	--	---	---

**OTHER CLINICAL INFORMATION (Check ALL that apply)**

<input type="checkbox"/> Yes <input type="checkbox"/> No Has patient failed treatment with NSAIDs? If yes, list names _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Does patient have ≥10% of BSA involvement
<input type="checkbox"/> Yes <input type="checkbox"/> No Does patient have an absolute contraindication to NSAIDs?	<input type="checkbox"/> Yes <input type="checkbox"/> No Does patient have ≤ 10% of BSA involving sensitive areas or areas that would significantly impact daily function (such as palms, soles of feet, head/neck, or genitalia)?
<input type="checkbox"/> Yes <input type="checkbox"/> No Has patient failed treatment with DMARDs? If yes, list names _____	<input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have a history of cancer?
<input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient had plaque psoriasis over one year?	<input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have a history of CHF?
<input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have severely restricted movement or immobilization?	<input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient had a negative PPD skin test?
<input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have a contraindication to Methotrexate or a history of intolerance to Methotrexate?	<input type="checkbox"/> Yes <input type="checkbox"/> No Will the patient be receiving the drug in the physician's office? If no, <b>list name</b> of servicing provider: _____
<input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient ever had an autoimmune disease diagnosis?	
<input type="checkbox"/> Yes <input type="checkbox"/> No Is the prescribing physician registered with the TOUCH program?	
<input type="checkbox"/> Yes <input type="checkbox"/> No Is TYSABRI® being prescribed along with other drugs for MS such as Avonex, Betaseron, or Rebif?	

<b>PHYSICIAN SIGNATURE</b>  Prescribing Physician _____	<b>DATE</b>  _____
---	--------------------------

**Note:** On behalf of Blue Cross and Blue Shield of Louisiana, prior authorizations are administered by Express Scripts, Inc., an independent pharmacy benefit management company. Please note that the authorization is not a guarantee of payment. Payment is subject to the member's eligibility, benefits, and pre-existing condition limitations at the time the services are provided. We recommend you contact BCBSLA at 800-922-8866 to verify benefits. The submitting provider certifies that the information contained herein is true, accurate, and complete and the requested services are medically necessary to the health of the patient.

**Incomplete forms will not be processed**