Pharmacy Administration - Prior Authorization / Exception Form
For questions, call **952-883-5813** or **800-492-7259**.
Incomplete or illegible submissions will be returned and may delay review.

HealthPartners®

FAX to 952-853-8700 or 1-888-883-5434

	Will waiting the standard review time **seriously jeopardize** the life or health of the member or the member's ability to regain maximum function?	Yes ☐ No ☐
Patient	Last Name / First Name / MI	
	Date of Birth / HealthPartners Insurance ID #	
	Address / Weight / BSA	
Provider	Today's Date / Clinic Name	
	Provider Name (FIRST and LAST) / Clinic Address	
	Specialty / Telephone #	
	Provider NPI / Fax #	
	Contact Person / Recommended by a Consultant? ☐Yes ☐ No; Name / Specialty	
Requested Therapy	Drug Requested & Dosing Schedule / Brand Name Necessary ☐ YES ☐ NO	
	Date Therapy Initiated / Requested Start Date	
	ICD-10 Diagnoses (Primary first)	
	Previous Therapies & Outcomes / Prescribing Rationale	
	If **injectable** medication, how is it being administered? ☐Self-administered ☐ Professionally-administered	
Facility	Administering Facility Information (**REQUIRED** for Professionally-administered drugs)	
	Name / Address	
	Federal Tax ID / NPI	
	Facility type: ☐ Clinic ☐Outpatient Hospital ☐Home Infusion ☐Ambulatory Infusion Suite	

HealthPartners Preferred Drug List (Formulary), Prior Approval and Medical Coverage Criteria are available at www.healthpartners.com

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Chronic Inflammatory Disease Form
Annual Reauthorization & High Dose Requests

Member Name: _____ Date of Birth:_____Patient's current Weight: _____

Member ID: _____

This form should be used for the following drugs:

• ACTEMRA®	• HUMIRA®	• RITUXAN®
• BENLYSTA®	• KINERET®	• SIMPONI®/ARIA®
• CIMZIA®	• KRYSTEXXA®	• STELARA®
• COSENTYX®	• ORENCIA®	• XELJANZ®
• ENBREL®	• OTEZLA®	
• ENTYVIO®	• REMICADE®	

**Rituxan only requires completion of this form if it's being prescribed for chronic inflammatory disease*

SECTION A: ANNUAL REAUTHORIZATION

Please complete section A for all renewal requests. The information will be used to review your request.

1. Has the patient been examined by your office within the last 14 months?
   Yes Last visit date:_____
   No

2. Check one of the following:
   ☐ This patient has achieved low disease activity or remission.
   ☐ This patient has achieved sufficient disease control to continue this agent.
   ☐ If neither of the above, please indicate why the drug should be continued below:
   _____
   _____

SECTION B: HIGH DOSE REQUEST

Completion of section B is required for all requests that exceed FDA- approved dosing. Please complete this section or submit supporting medical chart documentation that would address the below statements.

I have evaluated and counseled the patient and determine the following to be true:

1. The use of DMARD therapy in combination with this biologic has been **(check one)**:
   ☐ tried and failed to provide an acceptable level of disease control; or,
   ☐ tried and failed as an unacceptable toxicity resulted; or,
   ☐ is contraindicated

2. There is clinical rationale for why dosing for this drug should be increased beyond the FDA-approved regimen rather than switching to an alternative agent ☐ Yes ☐ No
3. The patient has been adherent to the regimen, as directed ☐ Yes ☐ No
4. The patient will be seen and disease control assessed at least annually ☐ Yes ☐ No

The chart below provides Average Wholesale Price (AWP) cost information for commonly prescribed agents at the FDA approved regimen and a higher dose regimen.

Drug	Annual Cost of Standard Regimen	Annual Cost of High Dose Regimen
ENBREL	50 mg once weekly = $69,295	50 mg twice weekly = $138,590
HUMIRA	40 mg every other week = $69,282	40 mg once weekly = $138,564
ORENCIA	SC: 125 mg once weekly = $59,726 IV: 1000 mg monthly = $61,591	SC: 125 mg twice weekly = $119,451 IV: 1000 mg twice monthly = $123,182
REMICADE	5mg /kg every 8 weeks = $36,426	10 mg/kg every 4 weeks = $145,704
SIMPONI **SIMPONI ARIA**	SC: 50 mg once monthly = $64,746 IV: 2 mg/kg every 8 weeks = $51,532	SC: 100 mg once monthly =$129,492 IV: 2 mg/kg every 4 weeks = $103,064
STELARA	90 mg every 12 weeks = $99,201 90 mg every 8 weeks = $148,802 (6 inj/yr)	90 mg every 4 weeks = $297,604 (12 inj/yr)
XELJANZ	5 mg twice daily = $59,214	10 mg twice daily = $118,428

Costs are for representative maintenance regimens. AWP may not be representative of the actual amount that members or the payer pay. AWP as of December 2017. Weight-based regimens were calculated based on an 80 kg patient.

**Please note all renewal requests for a more intense dose or interval for biologic therapies will require completion of section A and section B.*

Provider Name: _____

Provider Signature: _____ Date: _____