

# HEALTHY U MEDICAID

## PRIOR AUTHORIZATION REQUEST FORM

### SUBCUTANEOUS METHOTREXATE

Otrexup<sup>®</sup>, Rasuvo<sup>®</sup>, RediTrex<sup>™</sup>

**For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U Prior Authorization Department at 385-425-4052.**

**Failure to submit clinical documentation to support this request will result in a dismissal of the request.**

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

***Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.***

**Preferred:**  RediTrex<sup>®</sup>

**Non-preferred:**  Otrexup<sup>®</sup>,  Rasuvo<sup>™</sup>

Dosing/Frequency: \_\_\_\_\_

#### If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Has the member been diagnosed with severe, active rheumatoid arthritis or polyarticular juvenile idiopathic arthritis or severe, recalcitrant, disabling psoriasis?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member had a trial and failure with oral methotrexate?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Has the member had a trial and failure, with subcutaneous or intramuscular methotrexate?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Is the member unable to draw up methotrexate from a vial into a syringe or self-administer, due to mechanical, physical, or environmental factors?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

#### REAUTHORIZATION

1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member's therapy been re-evaluated within the past 6 months?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Has the therapy shown to be tolerable and effective with an improvement in condition?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Does the member show a continued medical need for the therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>

**What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.**

Additional information:

Physician's Signature:

**\*\* Failure to submit clinical documentation to support this request will result in a dismissal of the request.\*\***

Policy: PHARM-HU-070  
Origination Date: 01/01/2022  
Reviewed/Revised Date: 07/31/2023  
Next Review Date: 07/31/2024  
Current Effective Date: 10/01/2023

**Confidentiality Notice**

This document and any accompanying document contain confidential information and is intended for the use of the individual or entity named on this transmission sheet. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of any action in reliance on the contents of this information is strictly prohibited and the document should be returned to this office immediately. If you have received this facsimile in error, please notify us by telephone immediately and destroy document received.