REALRx

Healthy U
Health Choice Utah

PRIOR AUTHORIZATION REQUEST FORM

METHOTREXATE - SUBCUTANEOUS

Otrexup®, Rasuvo®

For authorization, please answer each question and fax this form PLUS chart notes back to the RealRx Medicaid 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 Pharmacy Customer Service for assistance.

- Healthy U Medicaid: 855-856-5694
- Health Choice Utah: 855-864-1404

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: ☐ Rasuvo™
Non-preferred: ☐ Otrexup®

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?	☐	☐	
2. Has the member had a trial and failure with oral methotrexate?	☐	☐	**Please provide documentation**
3. Has the member had a trial and failure, with subcutaneous or intramuscular methotrexate?	☐	☐	**Please provide documentation**
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?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member's therapy been re-evaluated within the past 6 months?	☐	☐	
3. Has the therapy shown to be tolerable and effective with an improvement in condition?	☐	☐	**Please provide documentation**
4. Does the member show a continued medical need for the therapy?	☐	☐	**Please provide documentation**

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:	
PRESCRIBER CERTIFICATION	
I hereby certify this treatment is indicated, necessary and meets the guidelines for use.	
Physician's Signature:	**Date:**

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Policy: PHARM-MM-070
Origination Date: 01/01/2022
Reviewed/Revised Date: 12/30/2024
Next Review Date: 12/30/2025
Current Effective Date: 01/01/2025

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