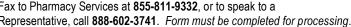
Request Form For Self Injectable Biological For Treating Arthritis (e.g. Enbrel® or Humira®) Fax to Pharmacy Services at 855-811-9332, or to speak to a Representative, call 888-602-3741. Form must be completed for processing.





Patient Name: Address:					District of Columbia		
					Patient ID #:		
					Apt # or Suite #:		
City:			State:		Zip Code:		
Phone #: Weight: _		ht:	lbs =		Birth Date:		
Physician Name:					NPI#:		
Address:					Apt # or Suite #:		
City:			State:		Zip Code:		
Contact Person:		P	Phone #:		Fax #:		
Physicia	an Signature:						
Drug to	be administered from (on): to			Or was administered	ed on: to be replaced to physician's office.		
Has the	member been evaluated for active or later	t TB infection?	☐ YES ☐ NO	Date	e of PPD (tuberculin skin test):		
Diagnosis:					ICD-9 Diagnosis Code:		
					Sig:		
attach a	any needed applicable documentation Drug	Dose	Start Date	End Date	Comments		
	Methotrexate (MTX)	Dose	Start Date	End Date	Comments		
	Combination Therapy						
	(i.e. Sulfasalazine, MTX, & Hydroxychloroquine)						
	Leflunomide (Arava®)						
	Etanercept (Enbrel®)*						
	Adalimumab (Humira®)*						
	Other ()						
*	These medications require prior authorizat	ion and will only	be approved when	the patient has a m	nedical reason for not taking the above oral formulary medications.		
Additio	nal Comments:						

PERFORMR