



**Arava® (leflunomide) Prior Authorization Request Form**

Please fax the completed request form to Mercy Health Plans' Pharmacy Department at 314-214-8201 or 800-466-9854. For additional information call 314-214-8282 or 800-647-2240

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_
Patient Pharmacy ID: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_
Requesting Physician: \_\_\_\_\_ Specialty: \_\_\_\_\_
Office Contact Person: \_\_\_\_\_ Phone #: (\_\_\_\_)\_\_\_\_-\_\_\_\_ext\_\_\_\_
Medication/dose Requested: \_\_\_\_\_ Fax #: \_\_\_\_ (\_\_\_\_)\_\_\_\_ - \_\_\_\_
Expected Duration of Therapy: \_\_\_\_\_ ICD-9 \_\_\_\_\_

INITIAL APPROVAL

- 1. Is the patient 18 years of age or older? YES NO
2. Does the patient have a diagnosis of rheumatoid arthritis? YES NO
3. Does the patient have a diagnosis of Felty's syndrome? YES NO
4. Does the patient have a diagnosis of other rheumatoid arthritis with visceral or systemic involvement? YES NO
5. Does the patient have a diagnosis of juvenile arthritis? YES NO
6. Does the patient have a diagnosis of psoriatic arthritis? YES NO
7. Has the patient tried and failed other therapy for the treatment of rheumatoid arthritis? YES NO
8. Is the patient female with childbearing potential? YES NO
9. Has pregnancy been excluded? YES NO
10. Has the patient been counseled on the potential serious risk to the fetus? YES NO
11. Will the patient have liver function testing done prior to beginning therapy and monthly for the first 6 months? YES NO
12. Will the patient have platelet, white blood cell counts and hemoglobin/hematocrit levels done prior to beginning therapy and monthly for the first 6 months? YES NO

RENEWAL APPROVAL

- 1. Is the patient 18 years of age or older? YES NO
2. Does the patient have a diagnosis of rheumatoid arthritis? YES NO
3. Does the patient have a diagnosis of Felty's syndrome? YES NO
4. Does the patient have a diagnosis of other rheumatoid arthritis with visceral or systemic involvement? YES NO
5. Does the patient have a diagnosis of juvenile arthritis? YES NO
6. Does the patient have a diagnosis of psoriatic arthritis? YES NO
7. Is the patient female with childbearing potential? YES NO
8. Has pregnancy been excluded? YES NO
9. Has the patient been counseled on the potential serious risk to the fetus? YES NO
10. Has the patient achieved at least an ACR 20 response after 6 months of therapy? YES NO
11. Are liver function tests being monitored and will they continue to be monitored every 6-8 weeks? YES NO
12. Are platelets, white blood cell counts, and hemoglobin/hematocrit being monitored every 6-8 weeks? YES NO

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

For Mercy Health Plans use only: Approved Length of Approval \_\_\_\_\_
Denied Reason for Denial \_\_\_\_\_
Reviewer's Signature: \_\_\_\_\_ Date Reviewed: \_\_\_\_/\_\_\_\_/\_\_\_\_
Override Entered in Caremark CCMS for \_\_\_\_\_ - \_\_\_\_\_ by \_\_\_\_\_
Office Notified on \_\_\_\_\_; at \_\_\_\_\_ am/pm; by \_\_\_\_\_ spoke to \_\_\_\_\_