MC-Rx
Powered by ProCare Rx

**Arava®** leflunomide

**Ticket #:** _____ **Request Date:** _____ **Request Time:** _____

# PHYSICIAN CERTIFICATION PRIOR AUTHORIZATION FORM

A request for the patient identified below has been made for the dispensing of **Arava®** leflunomide. Based on recent clinical information, we require more information before this prescription can be paid by the patient's health benefit plan. Please fill out the following information and return to us as indicated below:

| **A. Member Information** | | |
|---|---|---|
| Patient Name: | Plan Name/Plan ID: | |
| Patient ID: | Patient Date of Birth: | Patient Contact Phone #: |

| **B. Physician Information** | | | |
|---|---|---|---|
| Physician Name: | Physician Address: | | |
| Physician DEA #: | Physician Phone #: | Physician Fax #: | |
| Drug Name and Strength: | Direction (SIG): | QTY and Days Supply: | NDC #: |

| **C. Pharmacy Information** | | | |
|---|---|---|---|
| Pharmacy Name: | NABP #: | Pharmacy Phone #: | Pharmacy Fax #: |

**D. Clinical Information (Please fill out the following information: circle all that apply)**

| | | |
|---|---|---|
| 1. | Has the therapy been recommended by a rheumatologist? | YES NO |
| 2. | Does the patient have a current diagnosis of rheumatoid arthritis? | YES NO |
| 3. | Has the patient had a trial and inadequate response to <u>at least one</u> other disease modifying anti-rheumatic drug (DMARD) (e.g. Methotrexate, azathioprine, penicillamine, gold, hydroxychloroquine and sulfasalazine)? | YES NO |
| 4. | Is the patient female? If YES, continue to question 5. | YES NO |
| 5. | Has pregnancy been excluded? | YES NO |
| 6. | Have baseline LFT's been obtained for this patient? ***(Please attach a copy of the patient's baseline LFTs results.)*** | YES NO |

<u>Dosing recommendations</u>: Start with a loading dose of one 100mg tablet per day for 3 days, followed by 20mg QD.

| | |
|---|---|
| **Authorized Medical Signature:** | |
| **Telephone:** | **Date:** |

**<u>When Completed Return To</u>:**

MC-Rx Clinical Division, 1267 Professional Parkway, Gainesville, GA 30507
1-866-965-Drug (3784) / Fax # 866-999-7736

**Please note that this form is to be completed by the prescribing physician. This form and its contents are permissible under HIPAA as the protected health information (PHI) contained in this letter is only being used for purposes related to the provision of treatment, payment and healthcare operations (TPO). HIPAA does restrict the communication of PHI with providers for TPO related purposes.