Request Form For Self Injectable Biological
(e.g. Enbrel or Humira)

Fax to Perform Rx at **215-937-5018**, or to speak to Representative call **800-588-6767**. *Form must be completed for processing*.

FAX TO BANK'S APOTHECARY (215) 357 2129

Patient Name: _____ Keystone First ID#: _____

Address: _____ Apt # or Suite #: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Weight: _____lbs =_____Kg Birth Date:_____

Physician Name: _____ NPI #: _____

Address: _____ Apt # or Suite #: _____

City: _____ State: _____ Zip Code: _____

Contact Person: _____ Phone #: _____ Fax #: _____

Physician Signature:

_____

Drug to be administered from (on): _____ to _____ Or was administered on: _____ to be replaced to physician's office.

Has the member been evaluated for active or latent TB infection? ☐ YES ☐ NO Date of PPD (tuberculin skin test):_____

Diagnosis: _____ ICD-9 Diagnosis Code: _____

Drug Name: _____ Dose: _____ Sig: _____

❑ Deliver to Patient's Home ❑ Deliver to Physician's Office ❑ Pick-up at Local Pharmacy: BANK'S APOTHECARY #:2159276700

For prior authorization of self injectable biologic additional information is needed to proceed with review. Please identify the therapies attempted by completing the medication chart below indicating the dose, start date, end date and reasons for discontinuation (e.g. intolerance, hypersensitivity, other medical reasons). Please attach any needed applicable documentation

☑	Drug	Dose	Start Date	End Date	Comments
☐	Methotrexate (MTX)				
☐	Combination Therapy (i.e. Sulfasalazine, MTX, & Hydroxychloroquine)				
☐	Leflunomide (Arava®)				
☐	Etanercept (Enbrel®)*				
☐	Adalimumab (Humira®)*				
☐	Other ( )				

*These medications require prior authorization and will only be approved when the patient has a medical reason for not taking the above oral formulary medications.

Additional Comments:_____

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