

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

ARAVA (leflunomide)

Patient name: _____ Medicaid or SS# _____

Physician Name: _____ Contact person: _____

Phone#: _____ Ext. and opt. _____ Fax# _____

Pharmacy _____ Pharmacy Phone#: _____

All information to be legible, complete and correct or form will be returned

**FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF
MEDICAL NECESSITY TO (801) 536-0477**

CRITERIA:

- ▶ **DOCUMENTED** Severe Rheumatoid Arthritis
- ▶ **DOCUMENTED** history of treatment, incomplete response or intolerance to Methotrexate
- ▶ **DOCUMENTED** 6 or more swollen joints
- ▶ **DOCUMENTED** 9 or more tender joints
- ▶ **DOCUMENTED** rheumatology consultation within the last 60 days.
- ▶ May not be given with other biologic agents such as Interferon, experimental medications or combinations.

AUTHORIZATION:

Initial prior is for 6 months.

RE-AUTHORIZATION:

Subsequent PA is for 12 months if the patient has at least 20% **DOCUMENTED** improvement in 4 of the following 6 areas: tender and swollen joint count, patient and or global assessment of disease activity, pain, acute phase reactants.