Arava® (leflunomide) Prior Authorization Request Form

Please fax the completed request form to the Coventry Health Care Pharmacy Department at 877-815-8751. For additional information call 800-647-2240.

Patient Name: ____ Today's Date: _____/_______/_______

Patient Pharmacy ID: __________________________________ Date of Birth: _____/_______/________
(located on bottom right of insurance card)

Requesting Physician: _________________________________ Specialty: _________________________
(Please print)

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
   Drug(s) _______________________________ Reason for discontinuation _______________________________
   ______________________________________ ____
   ______________________________________ ____
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 _______________________

Created: 05/31/2005, Updated: 05/01/2011