

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM  
**ARAVA** (leflunomide)

Patient name: \_\_\_\_\_ Medicaid ID #: \_\_\_\_\_  
Prescriber Name: \_\_\_\_\_ Prescriber NPI#: \_\_\_\_\_ Contact person: \_\_\_\_\_  
Prescriber Phone#: \_\_\_\_\_ Extension/Option: \_\_\_\_\_ Fax#: \_\_\_\_\_  
Pharmacy: \_\_\_\_\_ Pharmacy Phone#: \_\_\_\_\_ Pharmacy Fax #: \_\_\_\_\_  
Requested Medication: \_\_\_\_\_ Strength: \_\_\_\_\_ Frequency/Day: \_\_\_\_\_

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

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**FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF  
MEDICAL NECESSITY TO 855-828-4992** note the new fax number

**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.

9/13/10

<http://health.utah.gov/medicaid/pharmacy>