

- Hydroxychloroquine (Plaquenil®)
- Other _____

- Orenzia® will not be used in combination with biologic DMARDS (TNF antagonists, such as Remicade®, Enbrel®, Humira®, Cimzia®) or used with other biologic RA therapy (such as anakinra, Kineret®)
- Individual does not have tuberculosis or other active serious infections or a history of recurrent infections
- Individual had a tuberculin skin test (TST) or Centers for Disease Control (CDC)-recommended equivalent to rule out latent tuberculosis
- Other _____

Other: _____

(2) Juvenile Idiopathic Arthritis

- Individual is 6 years or older and is diagnosed with moderately to severely active polyarticular juvenile idiopathic arthritis (JIA)
 - Orenzia® will be used to reduce signs and symptoms of the disease
 - Individual has had an inadequate response to a trial of one or more non-biologic or biologic DMARDS (such as Methotrexate or tumor necrosis factor (TNF) antagonists). Check any that apply:
 - Methotrexate
 - Sulfasalazine (Azulfidine®)
 - Hydroxychloroquine (Plaquenil®)
 - Remicade®
 - Enbrel®
 - Humira®
 - Cimzia®
 - Other _____
 - Orenzia® will be used as monotherapy (i.e. Orenzia® will not be used with other drugs such as those listed above)
 - Orenzia® will be used in combination with Methotrexate
 - Orenzia® will not be used in combination with biologic DMARDS (TNF antagonists such as Remicade®, Enbrel®, Humira®, Cimzia®) or used with other biologic RA therapy (such as anakinra, Kineret®)
 - Individual does not have tuberculosis or other active serious infections or a history of recurrent infections
 - Individual had a tuberculin skin test (TST) or Centers for Disease Control (CDC)-recommended equivalent to rule out latent tuberculosis
 - Other: _____

Other: _____

(3) Other Use(s) (Please submit all supporting documents including labs, progress notes, imaging, etc., for review.)

This request is being submitted:

- Pre-Claim
- Post-Claim. If checked, please attach the claim or indicate the claim number _____

I attest the information provided is true and accurate to the best of my knowledge. I understand that the health plan or its designee may perform a routine audit and request the medical documentation to verify the accuracy of the information reported on this form.

 Name & Title of Provider or Provider Representative Completing Form
 & attestation (Please Print)*

/ /
 Date

***The attestation fields must be completed by a provider or provider representative in order for the tool to be accepted**

 Anthem UM Services, Inc., a separate company, is the licensed utilization review agent that performs utilization management services on behalf of your health benefit plan or the administrator of your health benefit plan.