

**Physician's Prior Authorization Questionnaire
Arava (Leflunomide)®**

Patient:

ID#:

DOB:

Patient Address:

Arava® is covered under certain clinical conditions. The following information will help determine if this patient is eligible for coverage of treatment with this drug.

1. What is the patient's diagnosis? *(Please do not use codes.)* _____
2. Please detail the clinical course and current state of disease progression: _____

3. What is the present therapy? _____
4. Describe how present therapy has failed: _____

5. What other medications have been tried? _____

6. Describe how past therapy has failed: _____

7. Please clarify current therapy failures on slow-acting agents with explanation as to why this patient requires Arava®: _____

8. How long do you anticipate this treatment to last? _____
9. What is the physician's specialty? _____

Physician's Signature

Date

Please **Print** Physician's Name & Specialty

Phone Number

Fax Number

Thank you for your assistance and should you have any questions or wish to discuss, please feel free to contact the pharmacy department at (501) 378-3392. For your convenience, you may fax your response(s) back to (501) 378-6980.

Forms are also available online at www.usableadmin.com/providers/PharmacyForms.aspx