



PHYSICIAN'S PRIOR AUTHORIZATION QUESTIONNAIRE FOR METHOTREXATE INJECTIONS

PATIENT'S NAME: _____ ID#: _____ DOB: _____

Patient Address: _____

Methotrexate injections are covered under certain medical conditions. Please complete the following in order that we may determine if this patient meets medical criteria for prior authorization.

1. What is the medical diagnosis (Please do not use codes)? _____

2. Will Methotrexate be administered SQ or oral? _____

3. If SQ, has oral form been tried? _____ Yes _____ No

If yes, please indicate why oral form can no longer be given.

4. Will this medication be obtained and administered in physician's office? _____

OR

Will patient purchase from a participating pharmacy and self-administer (or bring back to the physician's office for administration)? _____

5. How long do you anticipate this therapy to last? _____

Physician's Signature Date

Please **Print** Name Fax Number

Please **Print** Physician's Specialty Phone Number

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

Sincerely,
Pharmacy Programs

Forms are also available online at <http://usableadmin.abcbs.net/providers/PharmacyForms.aspx>