

**Enbrel, Humira, Raptiva, Kineret  
Prior Authorization Form**

Enbrel, Humira, Raptiva and Kineret are specialty drugs that must be filled by Diplomat Pharmacy for GVHP patients.

Diplomat Specialty Pharmacy  
214 E Fulton Grand Rapids, MI 49503  
Ph No. 616-301-8200  
**For Prior Authorization please  
fax this form to: 616- 301-8201**



Date: \_\_\_\_\_ Patient SS# \_\_\_\_\_ Male Female  
Patient's first name \_\_\_\_\_ Patient's last name \_\_\_\_\_  
Patient's Address \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Ph \_\_\_\_\_ Cell Ph \_\_\_\_\_  
DOB: \_\_\_\_\_ Patient's weight \_\_\_\_\_ Recorded Date \_\_\_\_\_  
Caregiver: \_\_\_\_\_ Allergies \_\_\_\_\_

**Indications: check correct boxes**

- Reduction in the signs and symptoms of moderately to severely active rheumatoid arthritis in patients who have had an inadequate response to one or more **disease modifying antirheumatic drugs.**
- Reduction in the signs and symptoms of moderately to severely active polyarticularcourse juvenile rheumatoid arthritis in patients who have had an inadequate response to one or more **disease modifying antirheumatic drugs.**
- Reduction in the signs and symptoms and inhibiting the progression of active arthritis in patients with psoriatic arthritis.
- Reduction in the signs and symptoms in patients with active ankylosing spondylitis.
- Treatment of adult patients (18 years or older) with chronic moderate to severe plaque psoriasis who are candidates for systemic therapy or phototherapy.

**PRECERTIFICATION REQUIREMENTS:**

- Patient has a negative TB test result. Date of test: \_\_\_\_\_

**Medication**

Medication	DOSE	ROUTE	FREQUENCY	LENGTH	CYCLE	REFILLS
1. _____	_____	_____	_____	_____	_____	# ___ X ___ MONTHS
2. _____	_____	_____	_____	_____	_____	# ___ X ___ MONTHS
3. _____	_____	_____	_____	_____	_____	# ___ X ___ MONTHS

Ship to: Patient Physician/Clinic Other \_\_\_\_\_  
Physician's Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Physician's Name (please print) \_\_\_\_\_  
**PHYSICIAN SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_  
DEA # \_\_\_\_\_

Grand Valley Health Plan  
**For Internal Use Only**  
Approved by \_\_\_\_\_ Copy \_\_\_\_\_  
Date Entered in MEDIMPACT \_\_\_\_\_ Effective Date \_\_\_\_\_  
This Prior Authorization is valid and approved until \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
Status \_\_\_\_\_ Reviewed by \_\_\_\_\_ NDC: \_\_\_\_\_

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