

# Bravo Health

Coverage Review / Prior Authorization Request Form  
TNF Blocker/ Biological  
(Enbrel®, Humira®, Kineret®)



Patient Information		Prescriber Information	
Member Name:		Prescriber Name:	
Bravo ID #		Prescriber Specialty:	
DOB:		Prescriber Address:	
Address:			
		Office Phone#:	
Home Phone:		Office Fax #:	
		Contact Person:	

Diagnosis and Medication Requested		
Medication Requested (dosage, frequency):	Qty:	Length of Therapy:
Prescribing Diagnosis:	ICD9 Code	Date Therapy Initiated:

### Clinical Criteria

**Please answer the following questions:**

- Crohn's Disease: Has the patient experienced treatment failure with anti-inflammatory agents, corticosteroids, immunosuppressants? (Skip question 2)  
Yes      No  
**\*Please provide clinical notes or other documentation supporting intolerance or treatment failure for at least 3 months.**
- Has the patient experience intolerance or treatment failure (for at least 3 months) to methotrexate or another DMARD without concurrent TNF Blocker or other biological?  
Yes      No  
**\*Please provide clinical notes or other documentation supporting intolerance or treatment failure for at least 3 months.**
- Has the patient been evaluated and screened for the presence of latent TB infection prior to initiating treatment?  
Yes      No      Date of last PPD? \_\_\_\_\_ Result: \_\_\_\_\_

Additional Comments/Explanation:

**\*Failure to provide adequate data could result in denial of this request.**

Request for Expedited Review	
<input type="checkbox"/>	<b>REQUEST FOR EXPEDITED REVIEW [24 HOURS] BY CHECKING THIS BOX AND SIGNING BELOW, I CERTIFY THAT APPLYING THE 72 HOUR STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION</b>

**Prescriber's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Fax back to: 866-464-0709      For info call: 877-813-5595  
For additional Prior Authorization forms, go to <http://www.bravohealth.com/providers.aspx>