# PRIOR AUTHORIZATION REQUEST
## *Actemra*

PATIENT: Name_____
Address: _____
City, State, Zip_____
D.O.B. _____
Member ID:_____

Prescriber: Name_____
Address _____
City, State, Zip_____
Phone _____
Fax _____
NPI _____

**Medication Requested:_____ Qty Requested: _____**

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

## SECTION A: Please answer the following questions

1. Will Actemra be administered in combination with a BIOLOGIC or Targeted Synthetic disease-modifying antirheumatic drug used for an inflammatory condition?
   - ☐ Biologic DMARD
   - ☐ Targeted synthetic DMARD
   - ☐ Conventional synthetic DMARD – **Please answer questions 2 - 3**
   - ☐ No, Actemra will NOT be used in combination with another BIOLOGIC or Targeted Synthetic disease modifying antirheumatic drug (DMARD) – **Please answer questions 2 - 3**
2. ☐ Yes ☐ No Is the patient currently receiving Actemra (IV or SC)?
3. What is the indication or diagnosis?
   - ☐ Rheumatoid Arthritis (RA) – **Please answer questions 4 – 6, 15**
   - ☐ Giant cell arteritis (GCA) – **Please answer questions 6 – 7, 16**
   - ☐ Polymyalgia rheumatica (PMR) – **Please answer questions 6 – 7, 17**
   - ☐ Polyarticular Juvenile Idiopathic Arthritis (PJIA) – **Please answer questions 8 – 12, 18**
   - ☐ Systemic juvenile idiopathic arthritis (SJIA) – **Please answer questions 12 – 14, 18**
   - ☐ Crohn's disease
   - ☐ COVID-19 (Coronavirus Disease 2019). Note: This includes requests for patients with cytokine release syndrome associated with COVID-19 – **Please answer question 19**
   - ☐ All other indications or diagnoses – Please specify _____
4. ☐ Yes ☐ No Has the patient tried one conventional synthetic disease-modifying antirheumatic drug (DMARD) (brand or generic; oral or injectable) for at least 3 months?
5. ☐ Yes ☐ No Has the patient tried one biologic disease-modifying antirheumatic drug (DMARD) for at least 3 months?
6. ☐ Yes ☐ No Is Actemra (SC) being prescribed by or in consultation with a rheumatologist?
7. ☐ Yes ☐ No Has the patient tried one systemic corticosteroid? Note: An example of a systemic corticosteroid is prednisone.

**If you have any questions, call: 800-753-2851**

# PRIOR AUTHORIZATION REQUEST

## *Actemra*

8. ☐ Yes ☐ No Has the patient tried one other agent for this condition?
9. ☐ Yes ☐ No Will the patient be starting on Actemra SC concurrently with methotrexate (MTX), sulfasalazine, or leflunomide?
10. ☐ Yes ☐ No Does the patient have an absolute contraindication to methotrexate (MTX), sulfasalazine, or leflunomide?
11. ☐ Yes ☐ No Does the patient have aggressive disease, as determined by the prescriber?
12. ☐ Yes ☐ No Is the requested medication being prescribed by or in consultation with a rheumatologist?
13. ☐ Yes ☐ No Has the patient tried one other systemic agent for this condition?
14. ☐ Yes ☐ No Has the patient tried a biologic such a tumor necrosis factor (TNF) inhibitor?
15. ☐ Yes ☐ No Has the patient had a response, as determined by the prescriber?
16. ☐ Yes ☐ No Has the patient had a response, as determined by the prescriber?
17. ☐ Yes ☐ No Has the patient had a response, as determined by the prescriber?
18. ☐ Yes ☐ No Has the patient had a response, as determined by the prescriber?
19. Please provide the patient's diagnosis or indication, prescribed dose, frequency and route of administration, any other medications previously tried with duration of trial, and prescriber's or consultant's specialty. If the patient is already on this medication, when was it started?

_____

***Please document the diagnoses, symptoms, and/or any other information important to this review:***

_____

_____

**SECTION B** Physician Signature

_____

PHYSICIAN SIGNATURE DATE

**FAX COMPLETED FORM TO: 877-251-5896**

**Disclaimer:** An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior

**Disclaimer:** An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.



**If you have any questions, call: 800-753-2851**