maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Actemra Subq

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

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 note that supporting clinical documentation is required for **ALL** PA requests.

1	Will the requested medication be used in combination with other Biologics or with a Targeted Synthetic Disease-Modifying Antirheumatic Drug (DMARD)? [Note: Examples of biologics include but are not limited to adalimumab SC products (for example, Humira, biosimilars), Actemra (IV or SC), Cimzia, Cosentyx, an etanercept SC product (for example, Enbrel, biosimilars), Ilumya, Skyrizi, Kevzara, Kineret, Orencia (IV or SC), an infliximab IV product (for example, Remicade, biosimilars), a rituximab IV product (for example, Rituxan, biosimilars), Siliq, Stelara (IV or SC), Taltz, Tremfya, Entyvio, or Simponi (Aria or SC). Examples of Targeted Synthetic Disease-Modifying Antirheumatic Drugs include but are not limited to Cibinqo, Olumiant, Rinvoq, Xeljanz, Xeljanz XR.] [If yes, no further questions.]	Yes	No

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2	Is the patient currently receiving Actemra subcutaneous? [If no, skip to question 9.]	Yes	No
3	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 9.]	Yes	No
4	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 6.]	Yes	No
5	Has the patient been established on therapy for at least 3 months? [If yes, skip to question 7.] [If no, skip to question 9.]	Yes	No
6	Has documentation been submitted to confirm that the patient has had a clinically significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [if yes, skip to question 9.] [If no, no further questions.]	Yes	No
7	Has documentation been submitted to confirm that the patient has had a clinically significant response to therapy for at least 3 months, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
8	What is the diagnosis or indication? [] Giant cell arteritis (If checked, no further questions) [] Interstitial lung disease associated with systemic sclerosis (If checked, no further questions) [] Polyarticular juvenile idiopathic arthritis (PJIA) (If checked, no further questions) [] Rheumatoid arthritis (If checked, no further questions) [] Systemic juvenile idiopathic arthritis (SJIA) (If checked, no further questions) [] Polymyalgia rheumatica (PMR) (If checked, no further questions) [] COVID-19 (Coronavirus Disease 2019) (If checked, no further questions) [] Crohn's disease (If checked, no further questions) [] Other (If checked, no further questions)		

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9	What is the diagnosis or indication? [] Giant cell arteritis (If checked, go to 10) [] Interstitial lung disease associated with systemic sclerosis (If checked, go to 14) [] Polyarticular juvenile idiopathic arthritis (PJIA) (If checked, go to 23) [] Rheumatoid arthritis (If checked, go to 29) [] Systemic juvenile idiopathic arthritis (SJIA) (If checked, go to 34) [] Polymyalgia rheumatica (PMR) (If checked, go to 39) [] COVID-19 (Coronavirus Disease 2019) (If checked, no further questions) [] Crohn's disease (If checked, no further questions) [] Other (If checked, no further questions)		
10	Has the patient tried at least one systemic corticosteroid for at least 3 months? [Note: An example of a systemic corticosteroid is prednisone.] [If yes, skip to question 13.]	Yes	No
11	Has documentation been provided to confirm that the patient had an intolerance to at least one systemic corticosteroid? ACTION REQUIRED: Submit supporting documentation. [Note: An example of a systemic corticosteroid is prednisone.] [If yes, skip to question 13.]	Yes	No
12	Does the patient have relapsing Giant cell arteritis (GCA)? [If no, no further questions.]	Yes	No
13	Is this medication being prescribed by or in consultation with a rheumatologist? [If yes, skip to question 42.] [If no, no further questions.]	Yes	No
14	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
15	Does the patient have elevated acute phase reactants, defined as C-reactive protein (CRP) greater than or equal to 6 mg/mL? [If yes, skip to question 18.]	Yes	No
16	Does the patient have elevated acute phase reactants, defined as erythrocyte sedimentation rate (ESR) greater than or equal 28 mm/h? [If yes, skip to question 18.]	Yes	No
17	Does the patient have elevated acute phase reactants, defined as platelet count	Yes	No

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	greater than or equal 330 x 109/L? [If no, no further questions.]		
18	Does the patient have a forced vital capacity (FVC) that is greater than 55% of the predicted value? [If no, no further questions.]	Yes	No
19	Is the patient's diagnosis confirmed by high-resolution computed tomography? [If no, no further questions.]	Yes	No
20	Has the patient tried at least one other agent for this condition for at least 3 months? [Note: Examples of other agents tried includes mycophenolate, azathioprine.] [If yes, skip to question 22.]	Yes	No
21	Has documentation been provided to confirm that the patient had an intolerance to at least two other agents? ACTION REQUIRED: Submit supporting documentation. [Note: Examples of other agents tried includes mycophenolate, azathioprine.] [If no, no further questions.]	Yes	No
22	Is this medication being prescribed by or in consultation with a pulmonologist or rheumatologist? [If yes, skip to question 42.] [If no, no further questions.]	Yes	No
23	Has the patient tried at least one other prescription strength agent for this condition for at least 3 months? [Note: Examples of other agents tried includes methotrexate (MTX), sulfasalazine, leflunomide, or a prescription strength nonsteroidal anti-inflammatory drug (NSAID).] [If yes, skip to question 26.]	Yes	No
24	Has documentation been provided to confirm that the patient had an intolerance to at least two other agents? ACTION REQUIRED: Submit supporting documentation. [Note: Examples of other agents tried includes methotrexate (MTX), sulfasalazine, leflunomide, or a prescription strength nonsteroidal anti- inflammatory drug (NSAID).] [If yes, skip to question 26.]	Yes	No
25	Does the patient have aggressive disease, as determined by the prescriber? [If no, no further questions.]	Yes	No
26	Has documentation been provided to confirm that the patient had an intolerance, contraindication to, or failed treatment for at least 3 months with the preferred TNF inhibitors, Enbrel (etanercept) and an adalimumab product (Hadlima, Yusimry, or adalimumab- adbm)? ACTION REQUIRED: Submit supporting documentation.	Yes	No

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	[if no, no further questions.]		
27	Has documentation been provided to confirm that the patient had an intolerance, contraindication to, or failed treatment for at least 3 months with preferred JAK inhibitor, Xeljanz? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
28	Is this medication being prescribed by or in consultation with a rheumatologist? [If yes, skip to question 42.] [If no, no further questions.]	Yes	No
29	Has the patient tried at least one conventional synthetic disease-modifying antirheumatic drug (DMARD) for at least 3 months? [Note: Examples of conventional synthetic DMARDs include methotrexate (oral or injectable), leflunomide, hydroxychloroquine, and sulfasalazine.] [If yes, skip to question 31.]	Yes	No
30	Has documentation been provided to confirm that the patient had an intolerance to at least two conventional synthetic DMARDs? ACTION REQUIRED: Submit supporting documentation. [Note: Examples of conventional synthetic DMARDs include methotrexate (oral or injectable), leflunomide, hydroxychloroquine, and sulfasalazine.] [If no, no further questions.]	Yes	No
31	Has documentation been provided to confirm that the patient had an intolerance, contraindication to, or failed treatment for at least 3 months with preferred TNF inhibitors, Enbrel (etanercept) and an adalimumab product (Hadlima, Yusimry, or adalimumab- adbm)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
32	Has documentation been provided to confirm that the patient had an intolerance, contraindication to, or failed treatment for at least 3 months with preferred JAK inhibitor, Xeljanz? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
33	Is this medication being prescribed by or in consultation with a rheumatologist? [if yes, skip to question 42.] [If no, no further questions.]	Yes	No
34	Has the patient tried at least two other systemic agents for this condition for at least 3 months? [Note: Examples of one other systemic agents tried include a corticosteroid (oral, IV), a conventional synthetic disease-modifying antirheumatic drug (DMARD) (for example, methotrexate [MTX], leflunomide, sulfasalazine).] [If yes, skip to question 36.]	Yes	No
35	Has documentation been provided to confirm that the patient had an intolerance to at least two systemic agents? ACTION REQUIRED: Submit supporting	Yes	No

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	documentation. [Note: Examples of one other systemic agents tried include a corticosteroid (oral, IV), a conventional synthetic disease-modifying antirheumatic drug (DMARD) (for example, methotrexate [MTX], leflunomide, sulfasalazine).] [If no, no further questions.]		
36	Has documentation been provided to confirm that the patient had an intolerance, contraindication to, or failed treatment for at least 3 months with the preferred TNF inhibitors, Enbrel (etanercept) and an adalimumab product (Hadlima, Yusimry, or adalimumab- adbm)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
37	Has documentation been provided to confirm that the patient had an intolerance, contraindication to, or failed treatment for at least 3 months with the preferred JAK inhibitor, Xeljanz? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
38	Is this medication being prescribed by or in consultation with a rheumatologist? [If yes, skip to question 42.] [If no, no further questions.]	Yes	No
39	Has the patient tried at least one systemic corticosteroid for at least 3 months? [Note: An example of a systemic corticosteroid is prednisone.] [If yes, skip to question 41.]	Yes	No
40	Has documentation been provided to confirm that the patient had an intolerance to at least two systemic corticosteroids? ACTION REQUIRED: Submit supporting documentation. [Note: An example of a systemic corticosteroid is prednisone.] [If no, no further questions.]	Yes	No
41	Is this medication being prescribed by or in consultation with a rheumatologist? [No further questions.]	Yes	No
42	Does the requested dose exceed Food and Drug Administration (FDA) approved label dosing for the requested indication?	Yes	No

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

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SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

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.

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