

Actemra® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information <small>(required)</small>					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if requesting brand			Directions for Use:		
<input type="checkbox"/> Check if request is for continuation of therapy					
Clinical Information <small>(required)</small>					
Select the diagnosis below:					
<input type="checkbox"/> Moderate to severe rheumatoid arthritis					
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
For moderate to severe rheumatoid arthritis, answer the following:					
Is Actemra prescribed by a rheumatologist? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Has the patient tried and failed at least one previous disease modifying antirheumatic drug (DMARD) therapy (e.g., methotrexate, azathioprine, auranofin, hydroxychloroquine, sulfasalazine, leflunomide)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Select if the patient has tried and failed the following medications:					
<input type="checkbox"/> Cimzia SQ					
<input type="checkbox"/> Humira					
<input type="checkbox"/> Simponi					
Medication being provided by: (Please check applicable box below)					
<input type="checkbox"/> Physician's office <input type="checkbox"/> PropriumRx <input type="checkbox"/> Specialty Pharmacy (specify name): _____					
Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.					
Previous therapies will be verified through pharmacy paid claims or submitted chart notes.					
Prescriber Signature: _____				Date: _____	

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.
 For urgent or expedited requests please call 1-800-711-4555.
 This form may be used for non-urgent requests and faxed to 1-800-527-0531.