Please note: All information below is required to process this request.
Mon-Fri: 6am to 6pm Eastern / Sat: 6am to 6pm Eastern

Actemra® Prior Authorization Request Form (Page 1 of 2)

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

Member Information (required)			Provider Information (required)		
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 (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Moderate to severe rheumatoid arthritis
❑ Systemic juvenile idiopathic arthritis
❑ Other diagnosis: _____ ICD-10 Code(s): _____

For moderate to severe rheumatoid arthritis, answer the following:

Is Actemra prescribed by a rheumatologist? ❑ **Yes** ❑ **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)? ❑ **Yes** ❑ **No**

Select if the patient has tried and failed the following medications:

❑ Enbrel
❑ Humira
❑ Xeljanz/Xeljanz XR

For systemic juvenile idiopathic arthritis, answer the following:

Has the patient had systemic juvenile idiopathic arthritis for a minimum of 6 months? ❑ **Yes** ❑ **No**

Provide the date of diagnosis: _____

Has the patient had trial and failure of non-steroidal anti-inflammatory drugs (NSAIDs) and corticosteroids for greater than 3 months? ❑ **Yes** ❑ **No**

History of claims will be reviewed

Does the patient have greater than or equal to 5 active joints with fever for at least 2 weeks? ❑ **Yes** ❑ **No**

Does the patient have greater than or equal to 2 active joints with fever for at least 5 days? ❑ **Yes** ❑ **No**

Is the patient taking prednisone or equivalent 0.5 mg/kg/day or 30 mg/day? ❑ **Yes** ❑ **No**

Is the patient's C-reactive protein (CRP) greater than 15mg/L? ❑ **Yes** ❑ **No**

Does the patient have high erythrocyte sedimentation rate (ESR) greater than 45 mm/hr? ❑ **Yes** ❑ **No**

Has the patient had a fever greater than 38 degrees Celsius or 100.4 degrees Fahrenheit for at least 2 weeks? ❑ **Yes** ❑ **No**

Reauthorization for systemic juvenile idiopathic arthritis, also answer the following:

Will documentation of CRP or ESR along with progress notes to document therapy effectiveness be submitted along with this fax form? ❑ **Yes** ❑ **No**

Medication being provided by: (Please check applicable box below)

❑ Physician's office ❑ PropriumRx ❑ 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:** _____

Actemra® Prior Authorization Request Form (Page 2 of 2)

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

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.