PRO ACT PHARMACY BENEFIT MANAGEMENT

1230 US Highway 11
Gouverneur, NY 13642
Phone: 1-877-635-9545
Prior Authorization Fax: 1-844-712-8129

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

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:

❑ Active polyarticular juvenile idiopathic arthritis (PJIA) – For intravenous administration only
❑ Active systemic juvenile idiopathic arthritis (SJIA) – For intravenous administration only
❑ Giant cell arteritis
❑ Moderately to severely active rheumatoid arthritis (RA)
❑ Other diagnosis:_____ICD-10 Code(s): _____

Clinical Information:

Is Actemra prescribed by or in consultation with a rheumatologist? ❑ **Yes** ❑ **No**

Will the patient use Actemra in combination with a biologic DMARD [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)]? ❑ **Yes** ❑ **No**

For active polyarticular juvenile idiopathic arthritis (PJIA), also answer the following:

Does the patient have history of failure, contraindication, or intolerance to one of the following non-biologic disease modifying anti-rheumatic drugs (DMARDs): Arava (leflunomide) **OR** Rheumatrex/Trexall (methotrexate)? ❑ **Yes** ❑ **No**

For active systemic juvenile idiopathic arthritis (SJIA), also answer the following:

Does the patient have history of failure, contraindication, or intolerance to one non-steroidal anti-inflammatory drug (NSAID) [e.g., Motrin (ibuprofen), Naprosyn (naproxen)]? ❑ **Yes** ❑ **No**

Does the patient have history of failure, contraindication, or intolerance to systemic glucocorticoid (e.g., prednisone)? ❑ **Yes** ❑ **No**

For giant cell arteritis, also answer the following:

Has the patient had trial and failure, contraindication, or intolerance to glucocorticoid (i.e., prednisone)? ❑ **Yes** ❑ **No**

For moderately to severely active rheumatoid arthritis (RA), also answer the following:

Does the patient have history of failure, contraindication, or intolerance to one non-biologic disease modifying anti-rheumatic drug (DMARD) [e.g., Rheumatrex/Trexall (methotrexate), Arava (leflunomide), Azulfidine (sulfasalazine)]? ❑ **Yes** ❑ **No**

Select if the patient has history of failure, contraindication, or intolerance to the following:
❑ Cimzia (certolizumab) ❑ Humira (adalimumab) ❑ Simponi (golimumab) or Simponi Aria (golimumab IV)

Is this request for continuation of prior Actemra therapy? ❑ **Yes** ❑ **No**

Reauthorization:

If this is a reauthorization request, answer the following questions:

Is there documentation the patient has had a positive clinical response to Actemra therapy? ❑ **Yes** ❑ **No**

Will the patient use Actemra in combination with a biologic DMARD [e.g., Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)]? ❑ **Yes** ❑ **No**

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

Quantity Limit Requests:
What is the quantity requested per MONTH? _____
What is the reason for exceeding the plan limitations?
❑ Titration or loading dose purposes
❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
❑ Requested strength/dose is not commercially available
❑ Other: _____

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

_____

_____

Please note: This request may be denied unless all required information is received.

Please fax this form to 1-844-712-8129 to initiate a prior authorization review for the member and medication above.

Please note: plan benefits may limit or exclude coverage of specific medications including those requested on this form.

I certify, to the best of my knowledge, the statements and information provided on this form are factual and correct.

Provider/Representative (and Title): _____ **Date:** _____

PROACT INTERNAL USE ONLY:					
Clinical Review Decision					
	Approved, through				
	Denied (documentation attached, if necessary)				
Tracking:					
1st Attempt		2nd Attempt		Letter Mailed:	