carolina complete health

# Pharmacy Prior Approval Request for Immunomodulators: Actemra

**Beneficiary Information**

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: ____

**Prescriber Information**

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. ____

**Drug Information**

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days:_____
11. Length of Therapy (in days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days ☐ Other _____

**Clinical Information**

**Request for Polyarticular Juvenile Idiopathic Arthritis (PJIA):**

1. Does the beneficiary have a diagnosis of Polyarticular Juvenile Idiopathic Arthritis? ☐ **Yes** ☐ **No**
2. Is the beneficiary not on another injectable biologic immunomodulator? ☐ **Yes** ☐ **No**
3. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection? ☐ **Yes** ☐ **No**
4. Has the beneficiary been tested with Hep B SAG and Core Ab? ☐ **Yes** ☐ **No**
5. Has the beneficiary tried one systemic corticosteroid (e.g. prednisone, methylprednisolone) or methotrexate, leflunomide or sulfasalazine with inadequate response or is unable to take these therapies due to contraindications? ☐ **Yes** ☐ **No**
6. Does the beneficiary have PJIA subtype enthesitis related arthritis? ☐ **Yes** ☐ **No**
7. Has the beneficiary had a trial and failure of Enbrel or Humira or a clinical reason beneficiary cannot try Enbrel or Humira? ☐ **Yes** ☐ **No**

**Request for Systemic Onset Juvenile Idiopathic Arthritis (SJIA)**

1. Does the beneficiary have a diagnosis of Systemic Juvenile Idiopathic Arthritis? ☐ **Yes** ☐ **No**
2. Is the beneficiary not on another injectable biologic immunomodulator? ☐ **Yes** ☐ **No**
3. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection? ☐ **Yes** ☐ **No**
4. Has the beneficiary been tested with Hep B SAG and Core Ab? ☐ **Yes** ☐ **No**
5. Does the beneficiary have systemic arthritis with active systemic features and features of poor prognosis, as determined by the prescribing physician (e.g. arthritis of the hip, radiographic damage)? ☐ **Yes** ☐ **No**

Fax this form to (833) 404-2393 Pharmacy PA Call Center: (833) 585-4309

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**Request for Rheumatoid Arthritis:**

1. Does the beneficiary have a diagnosis of Rheumatoid Arthritis? ☐ **Yes** ☐ **No**
2. Is the beneficiary not on another injectable biologic immunomodulator? ☐ **Yes** ☐ **No**
3. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection? ☐ **Yes** ☐ **No**
4. Has the beneficiary been tested with Hep B SAG and Core Ab? ☐ **Yes** ☐ **No**
5. Has the beneficiary experienced a therapeutic failure/inadequate response with methotrexate or at least one disease modifying antirheumatic drug (e.g. leflunomide, hydroxychloroquine, minocycline sulfasalazine)? ☐ **Yes** ☐ **No**
6. Is the beneficiary unable to receive methotrexate or disease modifying antirheumatic drug due to contraindications or intolerabilities? ☐ **Yes** ☐ **No**
7. Does the beneficiary have clinical evidence of severe or rapidly progressing disease? ☐ **Yes** ☐ **No**
8. Has the beneficiary had a trial and failure of Enbrel or Humira or a clinical reason beneficiary cannot try either Enbrel or Humira? ☐ **Yes** ☐ **No**

**Request for Giant Cell Arteritis:**

1. Does the beneficiary have a diagnosis of Giant Cell Arteritis? ☐ **Yes** ☐ **No**
2. Is the beneficiary not on another injectable biologic immunomodulator? ☐ **Yes** ☐ **No**
3. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection? ☐ **Yes** ☐ **No**
4. Has the beneficiary been tested with Hep B SAG and Core Ab ☐ **Yes** ☐ **No**

**Request for Cytokine Release Syndrome:**

1. Does the beneficiary have a diagnosis of Cytokine Release Syndrome? ☐ **Yes** ☐ **No**
2. Is the beneficiary not on another injectable biologic immunomodulator? ☐ **Yes** ☐ **No**
3. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection? ☐ **Yes** ☐ **No**
4. Has the beneficiary been tested with Hep B SAG and Core Ab? ☐ **Yes** ☐ **No**

**Request for Systemic Sclerosis-Associated Interstitial Lung Disease (SSc-ILD)**

1. Does the beneficiary have a diagnosis of Systemic Sclerosis-Associated Interstitial Lung Disease? ☐ **Yes** ☐ **No**
2. Is the beneficiary not on another injectable biologic immunomodulator? ☐ **Yes** ☐ **No**
3. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection? ☐ **Yes** ☐ **No**
4. Has the beneficiary been tested with Hep B SAG and Core Ab? ☐ **Yes** ☐ **No**

Signature of Prescriber: _____ Date: _____

**(Prescriber Signature Mandatory)**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

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