

ACTEMRA**Prior Authorization Form**

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services.

Otherwise please return completed form to:

UPMC HEALTH PLAN PHARMACY SERVICES PHONE 800-979-UPMC (8762)

FAX 412-454-7722

PLEASE TYPE OR PRINT NEATLY*Please complete all sections of this form. Incomplete responses may delay this request*

Office Contact:		Provider Specialty: <input type="checkbox"/> Rheumatologist <input type="checkbox"/> Other (Please List):	
Provider First Name:		Provider Last Name:	
Provider Phone:		Provider Fax:	Provider NPI #:
Patient Name:	Patient UPMC Health Plan ID Number:	Patient DOB:	Patient Age:

Drug Requested:	Strength:	Frequency:	Qty Dispensed:
<input type="checkbox"/> Brand <input type="checkbox"/> Generic			

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

<input type="checkbox"/> New Medication <input type="checkbox"/> Ongoing Medication	If Ongoing Provide Date Started:	If medication is ongoing, did the member show improvement while on therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diagnosis:		Patient Height:	Patient Weight:
Please indicate place of administration:	<input type="checkbox"/> Physician's Office <input type="checkbox"/> Hospital/Clinic	Will the drug be: (select one) <input type="checkbox"/> Billed directly by the provider via JCODE JCODE: _____ <input type="checkbox"/> Billed by a pharmacy and delivered to the provider <input type="checkbox"/> Billed by a pharmacy and delivered to the patient	
Please provide hospital/facility name and address:			

MEDICAL HISTORY

Please indicate disease severity: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe			
Date of PPD (tuberculin) test: Result of PPD test: <input type="checkbox"/> Positive <input type="checkbox"/> Negative		Is there evidence of infection? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is the member currently using another TNF-blocking agent or biologic agent in combination with Actemra? If yes, please indicate drug name:			<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the member tried and failed Methotrexate for at least 3 months? Please indicate dates of therapy and dose:			<input type="checkbox"/> Yes <input type="checkbox"/> No
Please indicate reason for discontinuation:			
Please indicate if the member tried and failed any of the following for at least 3 months? <input type="checkbox"/> Leflunomide (Arava) <input type="checkbox"/> Minocycline (Minocin) <input type="checkbox"/> Sulfasalazine (Azulfidine) <input type="checkbox"/> Hydroxychlorquine (Plaquenil)			
Please provide dates of therapy and dose:			
Reason for discontinuation:			
Please indicate if the member tried and failed any of the following TNF blocking agents for at least 3 months? <input type="checkbox"/> Enbrel <input type="checkbox"/> Remicade <input type="checkbox"/> Cimzia <input type="checkbox"/> Humira <input type="checkbox"/> Simponi			
Please indicate dates of therapy and dose:			
Please indicate reason for discontinuation:			
Please provide the following laboratory values: AST: _____ Date of test: _____ Absolute neutrophil count: _____ Date of test: _____ ALT: _____ Date of test: _____ Platelet count: _____ Date of test: _____			

Please provide any additional information which should be considered in the space below:
