UPMC Health Plan

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
Incomplete responses may delay this request.

Office contact:		**Provider specialty:**	
Provider first name:		**Provider last name:**	
Provider phone #:		**Provider fax #:**	
Patient name:	**Patient UPMC Health Plan Member ID #:**	**Patient DOB:**	**Patient age:**
Drug requested: ☐ **Brand** ☐ **Generic**	**Strength:**	**Frequency:**	**Quantity dispensed (including units):**

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

☐ **New medication** ☐ **Ongoing medication**	**If ongoing, please provide start date:**	**If ongoing, did the member show improvement while on therapy?**	☐ **Yes** ☐ **No**
Diagnosis:		**Date of diagnosis:**	
Please indicate place of administration	☐ Physician office ☐ Hospital/Clinic ☐ Patient home	**Will the medication be (select one):** ☐ Billed directly by the provider via JCODE JCODE: _____ ☐ Billed by a pharmacy and delivered to the provider ☐ Billed by a pharmacy and delivered to the patient	
Please provide hospital/facility name and address:			

Please complete the following for all diagnoses:

Please indicate disease severity ☐ Mild ☐ Moderate ☐ Severe

Date of most recent tuberculosis skin test: _____. Result of tuberculosis skin test: ☐ Positive ☐ Negative

Does the member currently have evidence of infection? ☐ Yes ☐ No

Is the member currently using another TNF-blocking or biologic agent in combination with Actemra? ☐ Yes ☐ No
If yes, please provide name of medication: _____

Please indicate past medication(s) tried and failed:
(Actemra requires prior drug therapy of both preferred TNF products)

Medication name	Start date	End date	Strength	Frequency	Reason for failure or discontinuation
☐ **Methotrexate**					
☐ **Hydroxychloroquine**					
☐ **Leflunomide**					
☐ **Minocycline**					
☐ **Sulfasalazine**					
☐ **Cimzia**					
☐ **ENBREL****					
☐ **HUMIRA****					
☐ **Remicade**					
☐ **Simponi**					

Please be sure to complete and include the 2nd page of this form.

****ENBREL AND HUMIRA ARE THE PREFERRED TNF PRODUCTS FOR UPMC HEALTH PLAN**

ACTEMRA

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Patient Name	Patient UPMC Health Plan ID Number:	Patient DOB:

Please be sure to complete and include the 1st page of this form.

Please indicate past medication(s) tried and failed:

Medication name	Start date	End date	Strength	Frequency	Reason for failure or discontinuation
☐ **Non-Steroidal Anti-Inflammatory Drugs (please provide names):**					
☐ **Other (please provide names):**					

Please provide the following laboratory values:

Laboratory test	Date of test	Result (include units)
Absolute Neutrophil Count (ANC)		
Alanine Aminotransferase (ALT)		
Aspartate Aminotransferase (AST)		
Platelet Count		

Please indicate the diagnosis on the left and complete the corresponding questions.

☐ **Rheumatoid Arthritis** ☐ **Polyarticular Juvenile Idiopathic Arthritis**	Is the member's disease currently active?	☐ Yes ☐ No
☐ **Systemic Juvenile Idiopathic Arthritis**	Is the member's disease currently active? Please indicate if any of the following apply: ☐ Active fever ☐ Active arthritis ☐ Erythrocyte Sedimentation Rate (ESR) level greater than 2 times the upper limit of normal. Please provide level, units, and reference range: _____ ☐ C-Reactive Protein (CRP) greater than 2 times the upper limit of normal. Please provide level, units, and reference range: _____ _____	☐ Yes ☐ No
	Please provide chart documentation of clinical work-up to rule out other diagnoses and clinical rationale for this diagnosis. Please be sure to include the following: ☐ History of fever for at least 2 weeks in duration ☐ History of arthritis in more than one joint ☐ History of: ☐ Erythematous rash ☐ Hepatomegaly or splenomegaly ☐ Generalized lymph node involvement ☐ Pericarditis, pleuritis, or peritonitis	

Please provide any additional information in the space below.