OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

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)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
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)
- ❑ Active systemic juvenile idiopathic arthritis (SJIA)
- ❑ Cytokine release syndrome (CRS)
- ❑ Giant cell arteritis
- ❑ Moderately to severely active rheumatoid arthritis (RA)
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Prescriber's Specialty:

Select if Actemra is prescribed by or in consultation with one of the following specialists, as appropriate for the patient's diagnosis:

- ❑ Hematologist
- ❑ Oncologist Corlanor_FSVF_2019Jan
- ❑ Rheumatologist

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

Select if the patient has had trial and failure, contraindication, or intolerance to the following non-biologic disease modifying anti-rheumatic drugs (DMARDs):

- ❑ Arava (leflunomide)
- ❑ Rheumatrex/Trexall (methotrexate)

Has the patient had trial and failure, contraindication, or intolerance to Humira (adalimumab)? ❑ **Yes** ❑ **No**

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

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

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

For cytokine release syndrome, answer the following:

Wil the patient receive or is receiving chimeric antigen receptor (CAR) T-cell immunotherapy [i.e., Kymriah (tisagenlecleucel) Yescarta (axicabtagene ciloleucel)]? ❑ **Yes** ❑ **No**

For giant cell arteritis, answer the following:

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

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

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

Has the patient had trial and 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, or attestation demonstrating a trial may be inappropriate:

- ❑ Cimzia (certolizumab)
- ❑ Humira (adalimumab)
- ❑ Simponi (golimumab) or Simponi Aria (golimumab IV)

Select if the patient has history of failure, contraindication, or intolerance to the following:

- ❑ Kevzara (sarilumab)
- ❑ Xeljanz (tofacitinib) or Xeljanz XR (tofacitinib ER)

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

Reauthorization:

For active polyarticular juvenile idiopathic arthritis (PJIA), active systemic juvenile idiopathic arthritis (SJIA), giant cell arteritis, or moderately to severely active rheumatoid arthritis (RA) requests, answer the following questions:

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

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 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.