Health Partners Plans

HEALTH PARTNERS MEDICARE
PRIOR AUTHORIZATION REQUEST FORM

Actemra Prefilled Syringe - Medicare

Phone: 215-991-4300 **Fax back to: 866-371-3239**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Line of Business: □ Medicare	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:
Strength:
Directions / SIG:

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Does the patient have a documented diagnosis of Adult Rheumatoid Arthritis?
☐ Yes ☐ No

Q2. Does the patient have a documented diagnosis of Giant Cell Arteritis?
☐ Yes ☐ No

Q3. Does the patient have a documented diagnosis of Polyarticular Juvenile Idiopathic Arthritis (PJIA)?
☐ Yes ☐ No

Q4. Is the patient 18 years of age or greater for RA or GCA, or 2 years of age or greater for PJIA?
☐ Yes ☐ No

Q5. Is the prescriber an appropriate specialist such as a rheumatologist, or in consultation with an appropriate specialist such as a rheumatologist?
☐ Yes ☐ No

Q6. Has the patient failed, has contraindications or has had an inadequate response to at least one DMARD (such as sulfasalazine, leflunomide, hydroxychloroquine, methotrexate)?
☐ Yes ☐ No

Q7. Is there documentation of inadequate response or inability to tolerate one tumor necrosis factor antagonist (such as Enbrel or Humira)?

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Patient Name:	**Prescriber Name:**

☐ Yes ☐ No

Q8. Is a documented evaluation of Tuberculosis (TB) and Hepatitis B attached?

☐ Yes ☐ No

Q9. Is the patient being treated for any other active infection?

☐ Yes ☐ No

Q10. Is the patient going to be treated with Actemra concomitantly with a biological DMARD (e.g. Cimzia, Enbrel, Humira, Kineret, Orencia, Remicade, Rituxan, Simponi)?

☐ Yes ☐ No

Q11. Did the provider submit the following laboratory tests: A. Liver function tests (AST/ALT); B. Absolute neutrophil count (ANC); C. Platelet count?

☐ Yes ☐ No

Q12. Is the ANC less than 2000 per mm3 or platelet count below 100,000 per mm3 or does the patient have elevated transaminases ALT or AST greater than 1.5 times the upper limit of normal?

☐ Yes ☐ No

Q13. Duration:

☐ 12 months

Q14. Additional Information:

Q15. For CMS Reporting, where does the patient reside?

☐ 00 - Not specified, other patient residence not identified below
☐ 01 - Home
☐ 03 - Nursing Facility
☐ 04 - Assisted Living Facility
☐ 06 - Group Home
☐ 09 - Intermediate Care Facility/Mentally Retarded
☐ 11 - Hospice

Prescriber Signature

Date

2019 Medicare Prior Authorization Request