SENDERO HEALTH PLANS

Prior Authorization Request Form	**Actemra**
Sendero Fax: 512-901-9724	**Phone:** 855-297-9191
URGENCY: ☐ **STANDARD**	☐ **URGENT (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health or ability to regain maximum function)**

Provider Information	**Patient Information**
Referring/Prescribing Physician: ☐ **PCP** ☐ **Specialist** **Name:** **Please identify SPECIALTY:** **DEA, NPI or TIN:** **Contact:** **Phone: ( ) Fax: ( )**	**Patient's Name:** **Birth Date:** **ID Number:** **Phone Number:** **Patient Height:** **Patient Weight:**
Indicate where the drug is being DISPENSED	**Indicate where the drug is being ADMINISTERED**
☐ **Ambulatory Surgery Center** ☐ **Home Care Agency** ☐ **Inpatient Hospital** ☐ **Long Term Care** ☐ **Outpatient Hospital** ☐ **Pharmacy** ☐ **Patient's home** ☐ **Physician's Office** ☐ **Other (explain):**	☐ **Ambulatory Surgery Center** ☐ **Inpatient Hospital** ☐ **Long Term Care** ☐ **Outpatient Hospital** ☐ **Patient's Home** ☐ **Pharmacy** ☐ **Physician's Office** ☐ **Other (explain):** **Anticipated Date of Service:**

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

PATIENT CLINICAL INFORMATION

CRITERIA QUESTIONS:

1. What is the primary diagnosis?
   ☐ Rheumatoid arthritis (RA)
   ☐ Juvenile idiopathic arthritis (JIA) – polyarticular, oligoarticular, or systemic
   ☐ Giant cell arteritis (GCA)
   ☐ Other: _____

2. What is the HCPCS code? _____ What is the ICD-10 code? _____
   What is the NDC#: _____

3. Will the requested drug be used in combination with any other biologic or targeted synthetic DMARD (e.g., Olumiant, Xeljanz)? ☐ Yes ☐ No

4. Has the patient had a TB screening test (e.g., a tuberculosis skin test [PPD] or an interferon-release assay [IGRA]) within 6 months of initiating therapy? ☐ Yes ☐ No

5. What were the results of the TB screening test? ☐ Positive ☐ Negative

6. Does the patient have latent or active tuberculosis (TB)? ☐ Latent ☐ Active ☐ No/Neither

7. If the patient has latent or active tuberculosis, has treatment been initiated or completed?
   ☐ Yes - treatment initiated ☐ Yes - treatment completed ☐ No

8. Is this request for continuation of therapy? ☐ Yes ☐ No If No, skip to diagnosis section.

9. For continuation of therapy requests, has the patient achieved or maintained positive clinical response as evidenced by low disease activity or improvement in signs and symptoms since starting treatment with the requested drug? ☐ Yes ☐ No

10. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program? ☐ Yes ☐ No

DIAGNOSIS SECTION ***Please only complete sections below that are relevant to the patient's diagnosis.***

Section A: Rheumatoid Arthritis

11. The patient has diagnosis of rheumatoid arthritis and the treatment is prescribed by or in consultation with a rheumatologist. ☐ Yes ☐ No

12. Has the patient previously received a biologic or targeted synthetic DMARD (e.g., Rinvoq, Xeljanz) that is indicated for moderately to severely active rheumatoid arthritis? ☐ Yes ☐ No If Yes, please indicate the drug, duration, response, and intolerance/contraindication if applicable: _____

* Please note, the preferred biologic class is a TNF-inhibitor (specifically Cimzia). Please consider prescribing 1 of the TNF-inhibitor drugs, or Kevzara before Actemra if clinically appropriate. If Actemra is preferred please provide additional clinical reasoning documentation here:

_____

13. Has the patient experienced an inadequate response after at least 3 months of treatment with methotrexate 25mg PO weekly* ? ☐ Yes ☐ No If the methotrexate dose is unable to be increased to 25mg PO weekly, please indicate reason: _____

14. Has the patient experienced intolerance to methotrexate? ☐ Yes ☐ No If Yes, indicate intolerance: _____

15. Does the patient have a contraindication to methotrexate? ☐ Yes ☐ No If Yes, indicate contraindication: _____

Section B: Juvenile Idiopathic Arthritis (polyarticular, oligoarticular, systemic)

16. Has the patient previously received a biologic indicated for moderately to severely active articular juvenile idiopathic arthritis? ☐ Yes ☐ No If Yes, please indicate the drug, duration, response, and intolerance/contraindication if applicable: _____

17. Has the patient had an inadequate response to methotrexate or another non-biologic DMARD administered at an adequate dose and duration? ☐ Yes ☐ No

18. Does the patient have any of the following risk factors: a) positive rheumatoid factor or anti-CCP, b) pre-existing joint damage, c) high disease activity or high risk for disabling joint disease? ☐ Yes ☐ No

Section C: Giant Cell Arteritis

19. The patient has diagnosis of giant cell arteritis and the treatment is prescribed by or in consultation with a rheumatologist. ☐ Yes ☐ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by Sendero Health Plans.	
Prescriber or Authorized Signature	DATE

Sendero Health Plans ~Phone: 855-297-9191 ~Fax: 512-901-9724