Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Actemra

Phone: 215-991-4300 **Fax back to: 866-240-3712**

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:**	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Address:	NPI:	Promise ID:
City, State ZIP:	*Prescriber PA PROMISe ID:*	
Patient Primary Phone:	Address:	
Line of Business: □ Medicaid □ CHIP	City, State ZIP:	
	Specialty/facility name (if applicable):	

□ Expedited/Urgent

Drug Name:
Strength:
Days Supply:
Number of Refills:
Directions / SIG:

HPP's maximum approval time is 12 months but may be less depending on the drug.

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 patient have a diagnosis of moderately to severely active rheumatoid arthritis?
☐ Yes ☐ No

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

Q3. Is the patient 18 years of age or greater?
☐ Yes ☐ No

Q4. Is the prescriber a rheumatologist or in consultation with a rheumatologist?
☐ Yes ☐ No

Q5. Has the patient failed, has contraindications or has had an inadequate response (at least 3 months of treatment) to at least one DMARD (such as sulfasalazine, leflunomide, hydroxychloroquine, methotrexate)?
☐ Yes ☐ No

Q6. Has the patient failed, has contraindications or had an inadequate response to with Enbrel® and Humira® or is there any contraindication for patient to try Enbrel® and Humira®?
☐ Yes ☐ No

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Q7. Has the patient failed, has contraindications, or an inadequate response to corticosteroids or is the patient on concomitant tapering dose of corticosteroids?

☐ Yes ☐ No

Q8. Has the patient been evaluated for active or latent tuberculosis infection with a tuberculin skin test prior to the initiation of therapy?

☐ Yes ☐ No

Q9. Is the tuberculin skin test negative?

☐ Yes ☐ No

Q10. If latent infection is diagnosed, has the patient received appropriate treatment in accordance with the CDC and prevention guidelines?

☐ Yes ☐ No

Q11. Has the patient been screened for hepatitis B (antibody and/or surface antigen)?

☐ Yes ☐ No

Q12. Does the patient test positive for hepatitis B?

☐ Yes ☐ No

Q13. Is the patient being treated for any other active infection?

☐ Yes ☐ No

Q14. Does the provider submit the following laboratory tests? A. Liver function tests (LFTs); B. Absolute neutrophil count (ANC); C. Platelet count

☐ Yes ☐ No

Q15. 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

Q16. Requested Duration:

☐ 4 weeks

Q17. Additional Information:

Prescriber Signature

Date

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