



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

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.

Form with fields for Patient Name, HPP Member Number, Date of Birth, Address, City, State ZIP, Patient Primary Phone, Line of Business (Medicaid, CHIP), Prescriber Name, Fax, Phone, Office Contact, NPI, Promise ID, Prescriber PA PROMISe ID, Address, City, State ZIP, Specialty/facility name (if applicable).

Expedited/Urgent checkbox

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 checkbox

No checkbox

Q2. Does the patient have a documented diagnosis of Giant Cell Arteritis?

Yes checkbox

No checkbox

Q3. Is the patient 18 years of age or greater?

Yes checkbox

No checkbox

Q4. Is the prescriber a rheumatologist or in consultation with a rheumatologist?

Yes checkbox

No checkbox

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 checkbox

No checkbox

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 checkbox

No checkbox

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Prescriber Name:

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

Yes checkbox

No checkbox

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

Yes checkbox

No checkbox

Q9. Is the tuberculin skin test negative?

Yes checkbox

No checkbox

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

Yes checkbox

No checkbox

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

Yes checkbox

No checkbox

Q12. Does the patient test positive for hepatitis B?

Yes checkbox

No checkbox

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

Yes checkbox

No checkbox

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

Yes checkbox

No checkbox

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 checkbox

No checkbox

Q16. Requested Duration:

4 weeks checkbox

Q17. Additional Information:

Prescriber Signature

Date

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