CHORUS COMMUNITY HEALTH PLANS

ACTEMRA INTRAVENOUS

Prior Authorization Form for Chorus Community Health Plans Members

If this is an urgent request, please call Chorus Community Health Plans Pharmacy Services.

Otherwise, please return completed form – Phone: 844-201-4677 or Fax: 844-201-4675

PLEASE TYPE OR PRINT NEATLY

Incomplete responses may delay this request.

Office contact:	**Provider specialty:**
Provider first name:	**Provider last name:**

Provider phone #:	**Provider fax #:**	**Provider NPI #:**	
Patient name:	**Member ID #:**	**Patient DOB:**	**Patient age:**

Drug requested: **Brand** **Generic**	**Strength:**	**Frequency:**	**Quantity dispensed (including units):**

Generic equivalent drugs will be substituted for brand name drugs unless you specifically indicate otherwise.

New medication **Ongoing medication**	**If ongoing, please provide start date:**	**If ongoing, did the member show improvement while on therapy?**	**Yes** **No**

Diagnosis:	**Date of diagnosis:**

Please indicate place of administration:
Physician's office Hospital/clinic Patient home Other

Please provide hospital/facility name and address: **Name:** ____________________ **Phone #:** ____________________ **Address:** ____________________	**Will the drug be: (select one)** Billed medically using a JCODE JCODE: ____________________ Billed at a pharmacy

Please complete the following for all diagnoses:

Please indicate disease severity Mild Moderate Severe

Date of most recent tuberculosis skin test: _______________. Result of tuberculosis skin test: Positive Negative

Does the member currently have evidence of infection? Yes No

Is the member currently using another TNF-blocking or biologic agent in combination with Actemra? Yes No
If yes, please provide name of medication: ____________________

Please indicate past medication(s) tried and failed:

Medication name	Start date	End date	Strength	Frequency	Reason for failure, discontinuation
Methotrexate					
Hydroxychloroquine					
Leflunomide					
Minocycline					
Sulfasalazine					
Cimzia					
Enbrel					
Humira					
Remicade					
Simponi					

Please be sure to complete and include the 2nd page of this form.

ACTEMRA INTRAVENOUS

Patient Name	ID Number:	Patient DOB:

Please be sure to complete and include the 1st page of this form.

Please indicate past medication(s) tried and failed:

Medication name	Start date	End date	Strength	Frequency	Reason for failure, discontinuation
Non-Steroidal Anti-Inflammatory Drugs (please provide names):					
Other (please provide names):					

Please provide the following laboratory values:

Laboratory test	Date of test	Result (include units)
Absolute Neutrophil Count (ANC)		
Alanine Aminotransferase (ALT)		
Aspartate Aminotransferase (AST)		
Platelet Count		

Please indicate the diagnosis on the left and complete the corresponding questions.

Diagnosis	Questions	
Rheumatoid Arthritis Polyarticular Juvenile Idiopathic Arthritis	Is the member's disease currently active?	Yes No
Systemic Juvenile Idiopathic Arthritis	Is the member's disease currently active? Please indicate if any of the following apply: Active fever Active arthritis Erythrocyte Sedimentation Rate (ESR) level greater than 2 times the upper limit of normal. Please provide level, units, and reference range: ____ C-Reactive Protein (CRP) greater than 2 times the upper limit of normal. Please provide level, units, and reference range: ________________________ ____	Yes No
	Please provide chart documentation of clinical work-up to rule out other diagnoses and clinical rationale for this diagnosis. Please be sure to include the following: History of fever for at least 2 weeks in duration History of arthritis in more than one joint History of: Erythematous rash Hepatomegaly or splenomegaly Generalized lymph node involvement Pericarditis, pleuritis, or peritonitis	

Please provide any additional information in the space below.