Medical drug benefit
Prior authorization requests

WellSense HEALTH PLAN

Actemra

Version20 Effective: 06/30/2023

Phone: 877-417-1839 (NH Medicaid)
Fax: 866-539-7185

** Some plans might not accept this form for Medicare or Medicaid requests.*

This form is being used for:	
Check if Expedited Review/Urgent Request:	☐ (In checking this box, I attest to the fact that this request meets the definition and criteria for expedited review and is an urgent request.)

1. Patient information	
Patient Name:	DOB:
Member ID #:	

2. Prescriber information	
Prescribing Clinician:	Phone #:
Specialty:	Secure Fax #:
NPI #:	DEA/xDEA:
Prescriber Point of Contact Name (POC) (if different than provider):	
POC Phone #:	POC Secure Fax #:
POC Email (not required):	
Prescribing Clinician or Authorized Representative Signature:	Date:

3. Requested dosing

Please document the requested dosing:

4. Member's weight in kg

Please document the member's weight in kg:

5. Concurrent use

Will the member be using the requested medication concurrently with a biologic or a targeted synthetic DMARD?

☐ Yes

☐ No

6. Crohn's disease

Does the member have Crohn's disease?

☐ Yes

☐ No

7. Diagnosis

Please choose the appropriate diagnosis

☐ Cytokine Release Syndrome Associated with Chimeric Antigen Receptor (CAR) T-Cell Therapy (Proceed to Q10)

☐ COVID-19 (Proceed to Q11)

☐ Castleman's Disease (Proceed to Q17)

☐ Inflammatory Arthritis Associated with Checkpoint Inhibitor Therapy(Proceed to Q15)

☐ Polyarticular Juvenile Idiopathic Arthritis (PJIA)/Juvenile Rheumatoid Arthritis (JRA) (Proceed to Q8)

☐ Rheumatoid Arthritis (Proceed to Q9)

☐ Systemic Juvenile Idiopathic Arthritis (Proceed to Q14)

☐ Still's Disease(Proceed to Q16)

☐ Other, please indicate diagnosis below and include supporting clinical documentation for use in this indication and attached applicable chart notes in faxed request.

8. For Polyarticular Juvenile Idiopathic Arthritis (PJIA)/Juvenile Rheumatoid Arthritis (JRA)

Please choose *ALL* of the following that apply (Proceed to Q12)

☐ Member has tried Simponi Aria

☐ Member has heart failure or a previously treated lymphoproliferative disorder

☐ Member has been established on Actemra Intravenous or Actemra Subcutaneous for at least 90 days

☐ Other (please specify):

9. For Rheumatoid Arthritis

Please choose *ALL* of the following that apply (Proceed to Q11)

☐ Member has tried Simponi Aria or Cimzia or both

☐ The member has heart failure or a previously treated lymphoproliferative disorder

☐ Member has been established on Actemra Intravenous or Actemra Subcutaneous for at least 90 days

☐ Other (please specify):

10. For Cytokine Release Syndrome associated with (CAR) T-Cell Therapy

Has the member been or will be treated with a (CAR) T-cell therapy? (Proceed to Q18)

☐ Yes

☐ No

11. For COVID-19

Does the member have cytokine release syndrome associated with COVID-19? (Proceed to Q18)

☐ Yes

☐ No

12. For Polyarticular Juvenile Idiopathic Arthritis (PJIA)/Juvenile Rheumatoid Arthritis (JRA)

Please choose *ONE* of the following that apply (Proceed to Q17)

☐ Member has tried one other systemic therapy for this condition (e.g. methotrexate, sulfasalazine, leflunomide, or an NSAID)

☐ Member will be starting on Actemra intravenous concurrently with methotrexate, sulfasalazine, or leflunomide

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☐ Member has an aggressive disease

☐ Member has an absolute contraindication to methotrexate, sulfasalazine, or leflunomide (please specify the drug and associated contraindication)

☐ Other (please specify):

13. For Rheumatoid Arthritis

Please choose ALL of the following that apply (Proceed to Q17)

☐ Member has tried conventional synthetic DMARD for at least 3 months (e.g. methotrexate, leflunomide, hydroxychloroquine, and sulfasalazine)

☐ Other (please specify):

14. For Systemic Juvenile Idiopathic Arthritis

Please choose *ONE* of the following that apply (Proceed to Q17)

☐ Member has tried one other systemic therapy for this condition (e.g. corticosteroid, methotrexate, leflunomide, sulfasalazine, or a 1-month trial of an NSAID)

☐ Other (please specify):

15. For Inflammatory Arthritis associated with Checkpoint Inhibitor Therapy

Please choose *ALL* of the following that apply (Proceed to Q17)

☐ Member is symptomatic despite a trial of at least one systemic corticosteroid

☐ Member has tried at least one systemic nonsteroidal anti-inflammatory agent

☐ Other (please specify):

16. For Still's Disease

Please choose *ALL* of the following that apply (Proceed to Q17)

☐ Member has tried one corticosteroid

☐ Member has tried one conventional DMARD such as methotrexate for at least 2 months or was intolerant to a conventional synthetic DMARD

☐ Other (please specify):

17. Prescriber's specialty

Please indicate what specialty the prescriber is (select *any* that apply):

☐ Hematologist	☐ Oncologist
☐ Rheumatologist	

☐ Other (please indicate what specialty):

18. Initial or continuing therapy

Is the request for initial or continuing therapy?

☐ Initial (Proceed to Q22)

☐ Continuation (proceed to Q19)

19. Diagnosis

Please choose the appropriate diagnosis (Proceed to Q20)

☐ Castleman's Disease

☐ Inflammatory Arthritis Associated with Checkpoint Inhibitor Therapy

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☐ Polyarticular Juvenile Idiopathic Arthritis (PJIA)/Juvenile Rheumatoid Arthritis (JRA)

☐ Rheumatoid Arthritis

☐ Systemic Juvenile Idiopathic Arthritis

☐ Still's Disease

20. Response to therapy

Did the member have a response to therapy? (proceed to Q21)

☐ Yes

☐ No

21. Appropriate response to therapy

Please choose the appropriate response to therapy

☐ Decrease soft tissue swelling in joints or tendon sheaths

☐ Decrease in number of tender or swollen joints

☐ Improvement in limitation of motion

☐ Improved function or activities of daily living

☐ Improved laboratory values

☐ Increased body mass index (BMI) and reduction in lymphadenopathy

☐ Less joint pain, tenderness, morning stiffness or fatigue

☐ Normalization of C-reactive protein, erythrocyte sedimentation rate, fibrinogen, albumin, hemoglobin, or ferritin serum levels

☐ Resolution of fever

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☐ Reduced dosage of corticosteroids

☐ Resolution of constitutional symptoms

☐ Other, please specify:

22. HCPCS Codes

Please document the applicable HCPCS codes (e.g. J codes or Q codes) being requested, including the number of units and number of visits (using the space below):

☐ HCPCS / Qcodes:

☐ Number of units:

☐ Number of visits:

Providers should consult the health plan's coverage policies, member benefits, and medical necessity guidelines to complete this form. Providers may attach any additional data relevant to medical necessity criteria.