



NC Medicaid  
Pharmacy Prior Approval Request  
Immunomodulators: Actemra

**Beneficiary Information**

1. Beneficiary Last Name: \_\_\_\_\_ 2. First Name: \_\_\_\_\_  
3. Beneficiary ID #: \_\_\_\_\_ 4. Beneficiary Date of Birth: \_\_\_\_\_ 5. Beneficiary Gender: \_\_\_\_\_

**Prescriber Information**

6. Prescribing Provider NPI #: \_\_\_\_\_  
7. Requester Contact Information - Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Ext. \_\_\_\_\_

**Drug Information**

8. Drug Name: \_\_\_\_\_ 9. Strength: \_\_\_\_\_ 10. Quantity Per 30 Days: \_\_\_\_\_  
11. Length of Therapy (in days):  up to 30 Days  60 Days  90 Days  120 Days  180 Days  365 Days  Other \_\_\_\_\_

**Clinical Information**

**Request for Polyarticular Juvenile Idiopathic Arthritis (PJIA):**

1. Does the beneficiary have a diagnosis of Polyarticular Juvenile Idiopathic Arthritis?  Yes  No
2. Is the beneficiary not on another injectable biologic immunomodulator?  Yes  No
3. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection?  Yes  No
4. Has the beneficiary been tested with Hep B SAG and Core Ab?  Yes  No
5. Has the beneficiary tried one systemic corticosteroid (e.g. prednisone, methylprednisolone) or methotrexate, leflunomide or sulfasalazine with inadequate response or is unable to take these therapies due to contraindications?  Yes  No
6. Does the beneficiary have PJIA subtype enthesitis related arthritis?  Yes  No
7. Has the beneficiary had a trial and failure of Enbrel or Humira or a clinical reason beneficiary cannot try Enbrel or Humira?  Yes  No

**Request for Systemic Onset Juvenile Idiopathic Arthritis (SJIA)**

1. Does the beneficiary have a diagnosis of Systemic Juvenile Idiopathic Arthritis?  Yes  No
2. Is the beneficiary not on another injectable biologic immunomodulator?  Yes  No
3. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection?  Yes  No
4. Has the beneficiary been tested with Hep B SAG and Core Ab?  Yes  No
5. Does the beneficiary have systemic arthritis with active systemic features and features of poor prognosis, as determined by the prescribing physician (e.g. arthritis of the hip, radiographic damage)?  Yes  No

**Request for Rheumatoid Arthritis:**

1. Does the beneficiary have a diagnosis of Rheumatoid Arthritis?  Yes  No
2. Is the beneficiary not on another injectable biologic immunomodulator?  Yes  No
3. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection?  Yes  No
4. Has the beneficiary been tested with Hep B SAG and Core Ab?  Yes  No



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- 5. Has the beneficiary experienced a therapeutic failure/inadequate response with methotrexate or at least one disease modifying antirheumatic drug (e.g. leflunomide, hydroxychloroquine, minocycline sulfasalazine)?  Yes  No
- 6. Is the beneficiary unable to receive methotrexate or disease modifying antirheumatic drug due to contraindications or intolerabilities?  Yes  No
- 7. Does the beneficiary have clinical evidence of severe or rapidly progressing disease?  Yes  No
- 8. Has the beneficiary had a trial and failure of Enbrel or Humira or a clinical reason beneficiary cannot try either Enbrel or Humira?  Yes  No

**Request for Giant Cell Arteritis:**

- 1. Does the beneficiary have a diagnosis of Giant Cell Arteritis?  Yes  No
- 2. Is the beneficiary not on another injectable biologic immunomodulator?  Yes  No
- 3. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection?  Yes  No
- 4. Has the beneficiary been tested with Hep B SAG and Core Ab?  Yes  No

**Request for Cytokine Release Syndrome:**

- 1. Does the beneficiary have a diagnosis of Cytokine Release Syndrome?  Yes  No
- 2. Is the beneficiary not on another injectable biologic immunomodulator?  Yes  No
- 3. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection?  Yes  No
- 4. Has the beneficiary been tested with Hep B SAG and Core Ab?  Yes  No

**Request for Systemic Sclerosis-Associated Interstitial Lung Disease (SSc-ILD)**

- 1. Does the beneficiary have a diagnosis of Systemic Sclerosis-Associated Interstitial Lung Disease?  Yes  No
- 2. Is the beneficiary not on another injectable biologic immunomodulator?  Yes  No
- 3. Has the beneficiary been considered and screened for the presence of latent tuberculosis infection?  Yes  No
- 4. Has the beneficiary been tested with Hep B SAG and Core Ab?  Yes  No

Signature of Prescriber: \_\_\_\_\_ Date: \_\_\_\_\_

**(Prescriber Signature Mandatory)**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.