REALRx

PRIOR AUTHORIZATION REQUEST FORM

RHEUMATOID ARTHRITIS

Actemra®, Cimzia®, Enbrel®, Hadlima™, Humira®, Kevzara®, Kineret®, Olumiant®, Orencia®, Rinvoq®, Simponi®, Xeljanz®/XR

For authorization, please answer each question and fax this form PLUS chart notes back to Real Rx at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance 385-425-5094.

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try at least two formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred/Non-Preferred/Non-Formulary

1. Preferred
   A. Cimzia® (certolizumab), Enbrel® (etanercept), Hadlima™ (adalimumab-bwwd), Humira® (adalimumab), Simponi® (golimumab), Rinvoq® (upadacitinib), Xeljanz/XR (tofacitinib)
2. Non-preferred with a double step; after trial and failure of at least two preferred first line agents:
   A. Actemra® (tocilizumab), Orencia® (abatacept)
3. Non-Preferred with 4 steps; after trial and failure of at least two preferred first line agents AND both Actemra® (tocilizumab) and Orencia® (abatacept)
   A. Kineret® (anakinra), Olumiant® (baricitinib)
4. Excluded/Non-Formulary:
   A. Kevzara® (sarilumab)

Product being requested: _____

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Is the requested medication being purchased by the provider's office and to be billed under the medical benefit ('buy-and-bill')?	☐	☐	
2. Is this request for an **expedited** review? By checking the **"Yes"** box to request an expedited review (24 hours), you are certifying that applying the standard review time frame (72 hours) may place the member's life, health, or ability to regain maximum function in serious jeopardy.	☐	☐	
3. Is the member 18 years of age or older?	☐	☐	
4. Is the requesting provider a rheumatologist or in consultation with a rheumatologist?	☐	☐	

5. Is the patient's condition moderate to severe based on the Disease Activity Score (DAS28) or is a tender and swollen joint count provided as well as C-reactive protein (CRP) or erythrocyte sedimentation rate (ESR)?	☐	☐	**Please provide documentation**
6. Has the patient had an adequate trial and failure of at least one disease modifying antirheumatic drug (DMARD) (e.g. hydroxychloroquine, leflunomide, methotrexate, sulfasalazine) or contraindication to all?	☐	☐	**Please provide documentation**
7. If the request is for a Tumor Necrosis Factor Inhibitor or an Interleukin Receptor Antagonist, has the provider performed tuberculosis (TB) screening prior to therapy initiation?	☐	☐	**Please provide documentation**
8. If the request is for a Tumor Necrosis Factor Inhibitor, has the provider performed hepatitis B screening prior to therapy initiation?	☐	☐	**Please provide documentation**
9. If the request is for Olumiant, Rinvoq, or Xeljanz/XR, does documentation show an inadequate response or intolerance to at least one TNF (tumor necrosis factor) blocker such as an infliximab product, Cimzia, Enbrel, Humira and/or Simponi AND does documentation show the member will not be receiving Olumiant, Rinvoq, or Xeljanz/XR in combination with a potent immunosuppressant (e.g., azathioprine or cyclosporine)?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the patient experienced at least a 20% improvement in ACR or DAS28 score since therapy initiation? If moderate or high disease activity continues > 3 months due to lack of or loss of benefit, switching agents should be evaluated.	☐	☐	**Please provide documentation**
3. Has the provider performed continued tuberculosis monitoring during therapy?	☐	☐	**Please provide documentation**
4. Has the provider performed continued Hepatitis B monitoring in HBV carriers?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:

Physician's Signature:

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Policy PHARM-065
Origination Date: 03/14/2014
Reviewed/Revised Date: 09/13/2023
Next Review Date: 09/13/2024
Current Effective Date: 10/01/2023