REALRx

PRIOR AUTHORIZATION REQUEST FORM

GIANT CELL ARTERITIS

Actemra®, Rinvoq®

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 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

1. Preferred
    a. Rinvoq® (upadacitinib)
2. Non-Preferred agents with a single step; after trial and failure of Rinvoq®:
    a. Actemra® (tocilizumab)

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 request being made by a rheumatologist?	☐	☐	
4. Does the member has a diagnosis of giant cell arteritis confirmed by biopsy or imaging?	☐	☐	**Please provide documentation**
5. Does the member has elevated levels of C-reactive protein (CRP) AND erythrocyte sedimentation rate (ESR)?	☐	☐	**Please provide documentation**

6. Is the member currently taking prednisone (or equivalent) ≥ 20mg once daily?	☐	☐	**Please provide documentation**
7. Is the member taking JAK inhibitors, biologic DMARDS, or potent immunosuppressants such as azathioprine and cyclosporine?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the therapy been tolerable?	☐	☐	**Please provide documentation**
3. Has the member had improvement in at least one symptom (e.g. headache, scalp or jaw pain, fatigue, vision)?	☐	☐	**Please provide documentation**
4. Has the member had improvement in CRP and/or ESR levels?	☐	☐	**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 Signature:			

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Policy: PHARM-165
Origination Date: 06/11/2025
Reviewed/Revised Date: 06/11/2025
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