AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – Giant Cell Arteritis
(Actemra Infusion and Actemra SQ)

Beneficiary Information

1. Beneficiary Last Name: ________________________________ 2. First Name: ________________________________
3. Beneficiary ID #: ____________________ 4. Beneficiary Date of Birth: ____________ 5. Beneficiary Gender: _________

Prescriber Information

6. Prescriber Name: _______________________________________ NPI #: _________________________
Mailing address: ______________________________________ City: _____________ State: _________ ZIP: _______
7. Requester Contact Information: ____
Name: ______________________________ Phone #: ______________________ Fax #: _______________________

Drug Information

8. Drug Name: ______________ 9. Strength: _______________ 10. Quantity Per 30 Days: _____________
11. Length of Therapy: __up to 30 days __60 days __90 days __120 days __180 days __365 days __Other: ______

Clinical Information

1. Does the beneficiary have a diagnosis of Giant Cell Arteritis? Yes___ No___
2. Is the beneficiary on any other injectable immunomodulator? Yes___ No___
3. Has the beneficiary been screened for 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.

Fax this form to: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406

5/17/2021