

**Pharmacy Request for Prior Approval – Polyarticular Juvenile
Idiopathic Arthritis (PJIA)**
(Actemra Infusion, Actemra SQ, Enbrel, Humira, Ocrencia Infusion,
Ocrencia SQ, Simponi Aria, and Xeljanz)

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 Polyarticular Juvenile Idiopathic Arthritis? 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___
5. Has the beneficiary tried any of the following with inadequate response:
 Systemic corticosteroid or methotrexate
 Leflunomide or sulfasalazine
 Unable to take them due to contraindications
6. Does the beneficiary have PJIA subtype enthesitis related arthritis? Yes___ No___
7. Has the beneficiary tried and failed Enbrel or Humira? Yes___ No___
7a. If No, Please provide the clinical reason why the beneficiary has not tried Enbrel or Humira: _____

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.