



MEDICARE FORM

Actemra® (tocilizumab) Injectable Medication Precertification Request

Page 1 of 3

(All fields must be completed and legible for precertification review)

For Michigan MMP:

FAX: 1-844-241-2495

PHONE: 1-855-676-5772

For other lines of business:

Please use other form.

Note: Actemra is non-preferred.
Preferred products may vary based
on indication. See section G below.

Please indicate: Start of treatment: Start date ____ / ____ / ____
 Continuation of therapy: Date of last treatment ____ / ____ / ____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:		Last Name:		DOB:	
Address:			City:		State: ZIP:
Home Phone:		Work Phone:		Cell Phone: Email:	
Current Weight: _____ lbs or _____ kgs		Height: _____ inches or _____ cms		Allergies:	

B. INSURANCE INFORMATION

Aetna Member ID #: _____	Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
Group #: _____	If yes, provide ID#: _____ Carrier Name: _____
Insured: _____	Insured: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name:		(Check One): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A.	
Address:			City:		State: ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Office Contact Name:				Phone:	

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration: <input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Outpatient Infusion Center Phone: _____ Center Name: _____ <input type="checkbox"/> Home Infusion Center Phone: _____ Agency Name: _____ <input type="checkbox"/> Administration code(s) (CPT): _____ Address: _____ Please explain if there are any medical reason(s) why the patient cannot self-inject the requested drug: _____ _____ _____	Dispensing Provider/Pharmacy: <input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Mail Order <input type="checkbox"/> Other: _____ Name: _____ Address: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____
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E. PRODUCT INFORMATION

Request is for: <input type="checkbox"/> Actemra (tocilizumab) IV <input type="checkbox"/> Actemra (tocilizumab) SC
HCPCS Code: _____ Dose: _____
Frequency: _____

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable (*).

Primary ICD Code: _____	<input type="checkbox"/> Other ICD Code: _____
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G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

For Initiation requests (clinical documentation required):

Yes No Will Actemra (tocilizumab) be used concomitantly with apremilast, tofacitinib, or other biologic DMARDs (e.g., adalimumab, infliximab)?

Yes No Has the patient been tested for TB with a PPD test, interferon-release assay (IGRA) or chest x-ray within 6 months of initiating a biologic therapy?

(check all that apply): PPD test interferon-gamma assay (IGRA) chest x-ray

Please enter results of the TB test results: Positive Negative Unknown

If positive, Does the patient have latent or active TB? Latent Active

If latent TB, Yes No Will TB treatment be started before initiation of therapy with Actemra (tocilizumab)?

Note: Actemra is non-preferred. Remicade, Renflexis, and Simponi Aria are preferred for MA plans. Enbrel, Humira, Rinvoq, and Xeljanz are preferred for MAPD plans. Preferred products may vary based on indication.

Yes No Has the patient had prior therapy with Actemra (tocilizumab) within the last 365 days?

Yes No Has the patient had a trial, intolerance, or contraindication to any of the following? (select all that apply)

Remicade (infliximab) Renflexis (infliximab-abda) Simponi Aria (golimumab)

Yes No Has the patient had a trial, intolerance, or contraindication to any of the following? (select all that apply)

Enbrel (etanercept) Humira (adalimumab) Rinvoq (upadacitinib) Xeljanz (tofacitinib)

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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G. CLINICAL INFORMATION (continued) - Required clinical information must be completed in its entirety for all precertification requests.

Please explain if there are any other medical reason(s) that the patient cannot use any of the following preferred products when indicated for the patient's diagnosis (select all that apply)

- Remicade (infliximab)
- Renflexis (infliximab-abda)
- Simponi Aria (golimumab)

Please explain if there are any other medical reason(s) that the patient cannot use any of the following preferred products when indicated for the patient's diagnosis (select all that apply)

- Enbrel (etanercept)
- Humira (adalimumab)
- Rinvoq (upadacitinib)
- Xeljanz (tofacitinib)

Castleman's disease (CD)

- Yes No Is this request for IV formulation?
- Yes No Will Actemra (tocilizumab) be used as a monotherapy?
- Yes No Does the patient have unicentric CD?
 - Please identify if the patient has relapsed or refractory CD: Relapsed Refractory
 - Yes No Will Actemra (tocilizumab) be used a second-line therapy?
 - Yes No Is the patient human immunodeficiency virus (HIV) negative?
 - Yes No Is the patient human herpesvirus-8 (HHV-8) negative?
- Yes No Does the patient have documented multicentric CD?
 - Yes No Will Actemra (tocilizumab) be used as subsequent therapy?
- Yes No Has the disease progressed following treatment of relapsed/refractory or progressive disease?

Cytokine release syndrome

- Yes No Is this request for IV formulation?
- Yes No Does the patient have a documented diagnosis of chimeric antigen receptor (CAR) T cell-induced severe or life threatening cytokine release syndrome?

Giant cell arteritis

- Yes No Is this request for subcutaneous formulation?
- Yes No Has the patient had a temporal artery biopsy or cross-sectional imaging?
 - Please select which one: temporal artery biopsy cross-sectional imaging
- Yes No Does the patient have acute-phase reactant elevation (i.e., high erythrocyte sedimentation rate [ESR])?
- Yes No Does the patient have high serum C-reactive protein [CRP]?

Juvenile idiopathic arthritis (juvenile rheumatoid arthritis)

- Is this request for IV formulation or subcutaneous formulation? IV formulation subcutaneous formulation
- What is the severity of the patient's disease? Mild Moderate Severe
- Yes No Is there evidence that the disease is active?

Rheumatoid Arthritis

- Is this request for IV formulation or subcutaneous formulation? IV formulation subcutaneous formulation
- Please indicate the severity of the patient's rheumatoid arthritis: Mild Moderate Severe
- Yes No Is there evidence that the disease is active?
- Yes No Was treatment with methotrexate ineffective?
 - Yes No Was treatment with methotrexate not tolerated or contraindicated?
 - Please select: not tolerated contraindicated
 - Yes No Was treatment with another conventional DMARD (other than methotrexate) ineffective?
 - Provide select: azathioprine hydroxychloroquine leflunomide sulfasalazine

Systemic juvenile idiopathic arthritis

- Is this request for IV formulation or subcutaneous formulation? IV formulation subcutaneous formulation
- Yes No Is there evidence that the disease is active?
- Yes No Does the patient's initial symptoms include high fevers and painful polyarthritis?
- Yes No Was treatment with non-steroidal anti-inflammatory (NSAID) monotherapy ineffective?
 - Provide the name of the NSAID: _____

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G. CLINICAL INFORMATION (continued) - Required clinical information must be completed in its entirety for all precertification requests.

For ALL continuation of therapy requests (clinical documentation required for all requests):

- Yes No Is this continuation request a result of the patient receiving samples of Actemra (tocilizumab)?
- Yes No Will Actemra (tocilizumab) be used concomitantly with apremilast, tofacitinib, or other biologic DMARDs (e.g., adalimumab, infliximab)?
- Yes No Is there clinical documentation supporting disease stability?
- Yes No Is there clinical documentation supporting disease improvement?
- Yes No Does the patient have any risk factors for TB?
 - Yes No Has the patient had a TB test within the past year?
 - (check all that apply): PPD test interferon-gamma assay (IGRA) chest x-ray
 - Please enter the results of the TB test: Results: Positive Negative Unknown

For IV formulation requests only (continuation of therapy requests only):

- Yes No Has the patient received Actemra (tocilizumab) within the past 6 months?
 - Yes No Does the patient have a documented severe and/or potentially life-threatening adverse event that occurred during or following the previous infusion?
 - Yes No Could the adverse reaction be managed through pre-medication in the home or office setting?

For juvenile idiopathic arthritis (juvenile rheumatoid arthritis), rheumatoid arthritis or systemic juvenile idiopathic arthritis only:

Please indicate the severity of the patient's arthritis at baseline (pretreatment with Actemra (tocilizumab)): Mild Moderate Severe

H. ACKNOWLEDGEMENT

Request Completed By (Signature Required): _____ Date: ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.