aetna®

MEDICARE FORM

Actemra® (tocilizumab) Injectable Medication Precertification Request

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

For New Jersey HMO D-SNP:
FAX: 1-833-322-0034
PHONE: 1-844-362-0934

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 #: _____
Group #: _____
Insured:

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured:

C. PRESCRIBER INFORMATION

First Name:	Last Name: *(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.				
Address:		City:	State:	ZIP:	
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:	Office Contact Name:		Phone:		

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____
NPI: _____

Please explain if there are any medical reason(s) why the patient cannot self-inject the requested drug:

_____
_____
_____

Dispensing Provider/Pharmacy:
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order
☐ Other: _____
Name: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____
NPI: _____

E. PRODUCT INFORMATION

Request is for: ☐ Actemra (tocilizumab) IV
☐ Actemra (tocilizumab) SC
HCPCS Code: _____ **Dose:** _____
Frequency: _____

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

Primary ICD Code: _____ ☐ Other ICD Code: _____

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. Inflectra, Remicade, and Simponi Aria are preferred for MA plans. Enbrel, Humira, Kevzara, Rinvoq, and Xeljanz/Xeljanz XR 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 and failure, intolerance, or contraindication to any of the following? (select all that apply)
☐ Inflectra (infliximab-dyyb) ☐ Remicade (infliximab) ☐ Simponi Aria (golimumab)

☐ Yes ☐ No Has the patient had a trial and failure, intolerance, or contraindication to any of the following? (select all that apply)
☐ Enbrel (etanercept) ☐ Humira (adalimumab) ☐ Kevzara (sarilumab) ☐ Rinvoq (upadacitinib) ☐ Xeljanz/Xeljanz XR (tofacitinib)

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

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)

☐ Inflectra (infliximab-dyyb) ☐ Remicade (infliximab) ☐ 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) ☐ Kevzara (sarilumab) ☐ Rinvoq (upadacitinib) ☐ Xeljanz/Xeljanz XR (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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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

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.