

# Pharmacy PRIOR AUTHORIZATION FORM

For Prior Authorization, please fax to: (877) 974-4411 toll free, or (616) 942-8206

 This form applies to:  Commercial Plan  Medicaid Plan  Medicare Plan

## Actemra<sup>®</sup> (tocilizumab)

 **URGENT** (life threatening)

 **Non-Urgent** (standard review)

 A claim involving "urgent care" applies when the standard review time will seriously jeopardize the life or health of the member, or subject the member to severe pain that cannot be managed without the care or treatment requested in the subject of this request. **Priority Health averages between 1 and 3 business days for our standard review response time.**

### Member Information

Member Name:	Member No.:
DOB:	Gender:
Member's PCP:	

### Provider Information

Provider Name:	
Office Contact Name:	Provider Phone:
Provider NPI:	Provider Fax:
Provider Address:	

 \_\_\_\_\_  
 Provider Signature

 \_\_\_\_\_  
 Date

### PRODUCT INFORMATION

 Actemra<sup>®</sup> 20mg/mL Solution for Injection (single use vial)

**Start Date:** \_\_\_\_\_

**Dose:** \_\_\_\_\_

**Patient weight:** \_\_\_\_\_

Dosing Information:

<b>Rheumatoid Arthritis</b>	The recommended starting dose is 4 mg/kg followed by an increase to 8 mg/kg based on clinical response (maximum of 800 mg per infusion), given every 4 weeks
<b>Systemic Juvenile Idiopathic Arthritis</b> <i>(weight based dosing)</i>	Patients less than 30 kg: 12 mg/kg every 2 weeks
	Patients at or above 30 kg: 8 mg/kg every 2 weeks

### BILLING INFORMATION

**Place of administration:**
 Provider's Office

 Outpatient Infusion Center

Center Name: \_\_\_\_\_

 Home Infusion

Agency Name: \_\_\_\_\_

**Billing Options:**
 Physician buy and bill

 Preferred Specialty Vendor

 Other: \_\_\_\_\_

**Request:**
 New – Complete Section A

 Continuation – Complete Section B

**PRIORITY HEALTH PRECERTIFICATION REQUIREMENTS**

 Authorization for Actemra<sup>®</sup> (tocilizumab) requires the following information to certify:

**Patient must have met the following requirements:**

- Diagnosis of moderate to severe rheumatoid arthritis in adults or systemic juvenile idiopathic arthritis in patients 2 years of age or older
- Documentation of a therapeutic trial and clinical failure with at least one self-injectable anti-TNF therapy
- Documentation of an annual negative TB test result
- Pretreatment labs completed and within normal limits (i.e. CBC with diff, LFTs, lipid panel)
- Patient must not be receiving Actemra<sup>®</sup> in combination with another biologic drug
- Patient may be receiving therapy with a non-biologic DMARD along with Actemra<sup>®</sup>

**For continuation, patient must have met the following requirements:**

- The patient is compliant in taking the medication as scheduled
- The patient tolerated the medication
- The patient did not experience any severe adverse reactions while taking the medication
- The patient has responded to treatment, with at least ACR 20 response
- The patient had a negative TB test result in the previous 12 months
- The patient's ANC, platelet count, LFT, and lipid panel are within acceptable ranges

**SECTION A – NEW THERAPY**
**PRIORITY HEALTH PRECERTIFICATION DOCUMENTATION**

 Authorization for Actemra<sup>®</sup> (tocilizumab) requires the following information to certify:

**A. What is the patient's diagnosis?**

- a.  Rheumatoid Arthritis ICD code: \_\_\_\_\_
- b.  Systemic Juvenile Idiopathic Arthritis ICD code: \_\_\_\_\_
- c.  Other: \_\_\_\_\_
- Rationale for use:* \_\_\_\_\_

Note: Authorization for indications not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the drug's use for the identified indication.

**B. What self-injectable anti-TNF drug has the patient had a documented therapeutic trial and clinical failure with?**

- Enbrel<sup>®</sup> (age 2 and older) Dates of therapy: \_\_\_\_\_
- Humira<sup>®</sup> (age 4 and older) Dates of therapy: \_\_\_\_\_
- Other: \_\_\_\_\_
- Rationale for use:* \_\_\_\_\_

**C. What is the result of the patient's TB test completed within the previous 12 months?**

- negative
- positive – *Rationale for use:* \_\_\_\_\_
- test not completed – *Rationale for use:* \_\_\_\_\_

**D. Pre-treatment labs were completed, including Absolute Neutrophil Count (ANC), platelets, lipid panel, and liver function tests (AST, ALT), all within normal limits.**

- Yes
- No – *Rationale for use:* \_\_\_\_\_

**E. Will the patient be receiving Actemra<sup>®</sup> in combination with any other biologics (e.g. Enbrel<sup>®</sup>, Humira<sup>®</sup>, Kineret<sup>®</sup>, Remicade<sup>®</sup>, Orencia<sup>®</sup>, Rituxan<sup>®</sup>)?**

- No  
 Yes – *Rationale for use:* \_\_\_\_\_

## SECTION B – CONTINUATION

*to be completed for patient's in which Actemra<sup>®</sup> (tocilizumab) was previously authorized by Priority Health*

### PRIORITY HEALTH PRECERTIFICATION DOCUMENTATION

Authorization for continuation of Actemra<sup>®</sup> (tocilizumab) requires the following information to certify:

**A. What is the patient's diagnosis?**

- a.  Rheumatoid Arthritis ICD code: \_\_\_\_\_  
 b.  Systemic Juvenile Idiopathic Arthritis ICD code: \_\_\_\_\_  
 c.  *Other:* \_\_\_\_\_  
*Rationale for use:* \_\_\_\_\_

Note: Authorization for indications not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the drug's use for the identified indication.

**B. Select which of the following apply (all must be met for continuation of therapy):**

- The patient is compliant in taking the medication as scheduled  
 The patient tolerated the medication  
 The patient did not experience any severe adverse reactions while taking the medication  
 The patient has responded to treatment, as determined by the prescribing physician (at least ACR 20 response)  
 The patient has been monitored for neutrophils, platelets, LFTs every 4 to 8 weeks, and a lipid panel was completed 4 to 8 weeks after starting therapy and then every 6 months thereafter. Dosing adjustments, treatment interruption, or discontinuation may be necessary if laboratory parameters are not corrected.  
 The patient had a negative TB test result in the previous 12 months. Date of test: \_\_\_\_\_

### PRIORITY MEDICARE PLANS

**Note:** Priority Health Medicare applies CMS national and local coverage determination criteria when available for Part B drugs. If no national determination criteria or local coverage determination criteria is available for the state in which the member is receiving the services, the above prior authorization criteria must be met.

**\*\*\* All fields must be complete and legible for Prior Authorization Review\*\*\*  
 Please fax this request to: (877)974-4411 toll free or (616)942-8206  
 YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX**