# Priority Health Medicare prior authorization form

**Fax completed form to: 877.974.4411 toll free, or 616.942.8206**

This form applies to: ☐ **Medicare Part B** ☒ **Medicare Part D**
This request is: ☐ **Expedited request** ☐ **Standard request**

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

# Actemra® (tocilizumab)

## Member

Last Name: _____ First Name: _____
ID #: _____ DOB: _____ Gender: _____
Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____
Provider Address: _____
Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

## Product Information

☐ New Request ☐ Continuation Request

Drug product:
☐ Actemra 162 mg prefilled syringe
☐ Actemra ACTpen 162 mg autoinjector

**Start date** (or date of next dose): _____
**Date of last dose** (if applicable): _____
**Dosing frequency:** _____

## Prior authorization criteria

The following requirements need to be met before this drug is covered by Priority Health Medicare. These requirements have been approved by the Centers for Medicare and Medicaid Services (CMS), but you may ask us for an exception if you believe one or more of these requirements should be waived.

**For this drug to be covered, the patient must meet the following criteria:**

1. Must have a medically-accepted indication*
2. For a diagnosis of rheumatoid arthritis, must first try and fail Humira or Enbrel
3. Must have a negative TB test result in the past 12 months
4. Must not be given in combination with other biologic drugs

## Medically-accepted indication*

This drug is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- — *or* — supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information and the DRUGDEX Information System.)

## Additional information

**Note:** When criteria are met, initial coverage duration is 16 weeks with subsequent approvals for 12 months.


**All fields must be complete and legible for review. Your office will receive a response via fax.**
Updated 01/2019
Last reviewed 01/2019

## Priority Health Precertification Documentation

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

- ☐ Rheumatoid arthritis
  - **1. Has the patient tried and failed Humira or Enbrel?**
    - ☐ Yes
    - ☐ No. **Are you requesting an exception to the criteria?**
      - ☐ Yes. ***Rationale for exception***: _____
      - ☐ No
- ☐ Polyarticular juvenile idiopathic arthritis
- ☐ Systemic juvenile idiopathic arthritis
- ☐ Giant cell arteritis
- ☐ Cytokine release syndrome, chimeric antigen receptor (CAR) T cell-induced
- ☐ *Other – the patient's condition is:* _____

**B. Has the patient had a TB test in the past 12 months?**

- ☐ Yes
  - ☐ negative Date: _____
  - ☐ positive
- ☐ No. **Are you requesting an exception to the criteria?**
  - ☐ Yes. ***Rationale for exception***: _____
  - ☐ No

**C. Will the patient receive Actemra in combination with another biologic drug (e.g. Enbrel, Humira, Kineret, Remicade, Orencia, or Rituxan)?**

- ☐ No
- ☐ Yes. **Are you requesting an exception to the criteria?**
  - ☐ Yes. ***Rationale for exception***: _____
  - ☐ No

## Priority Health Medicare Exception Request *(exceptions to the above criteria)*

**Do you believe one or more of the prior authorization requirements should be waived?** ☐ Yes ☐ No
If yes, you must provide a statement explaining the medical reason why the exception should be approved.

**Would Actemra likely be the most effective option for this patient?**
☐ Yes ☐ No
If yes, please explain why: _____

_____

_____

**If the patient is currently using Actemra, would changing the patient's current regimen likely result in adverse effects for the patient?**
☐ Yes ☐ No
If yes, please explain: _____

_____

_____


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