PriorityHealth

Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)** ☐ **Medicaid**

This request is: ☐ **Urgent (life threatening)** ☐ **Non-Urgent (standard review)**

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Actemra® (tocilizumab)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Physician: _____ Phone: _____ Fax: _____

Physician Address: _____

Physician NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product and Billing Information

☐ New request ☐ Continuation request

Drug product:
- ☐ Actemra 20 mg/mL vial
- ☐ Actemra 162 mg/0.9 mL syringe

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Date of next dose (if applicable): _____

Dose: _____ **Dose Frequency**: _____

Patient's weight: _____

Administration:
- ☐ Physician's Office
- ☐ Outpatient Infusion
  - Facility: _____ NPI: _____ Fax #: _____
- ☐ Home infusion
  - Agency: _____ NPI: _____ Fax #: _____

Billing:
- ☐ Physician Buy and Bill
- ☐ Facility Buy and Bill
- ☐ Specialty Pharmacy
  - Pharmacy: _____ NPI: _____ Fax #: _____

ICD-10 Code(s): _____

ACTEMRA COVERAGE POLICY

- Before Actemra is covered, the patient must meet all of the General Criteria for Actemra and all of the Specific Criteria for the treatment diagnosis. If these criteria are not met, the prescriber must provide an explanation of why an exception to the criteria is necessary.
- Coverage for a diagnosis not listed below will be considered on a case by case basis. Please provide rationale for use and all pertinent patient information.
- Actemra will not be covered in combination with another biologic drug.
- Please provide rationale when requesting any dose or dosing interval not listed in the FDA label.

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 01/2018

Last reviewed 01/2019

Criteria

General Criteria for ALL Diagnoses:

a) Patient has evidence of a negative TB test result in the past 12 months (or TB is adequately managed); AND
b) Prescriber is a specialist or has consulted with a specialist for the condition being treated.

Specific Criteria for Individual Diagnoses:

1. Polyarticular Juvenile Idiopathic Arthritis
   a) Patient has tried methotrexate for a period of at least 3 months; AND
   b) Patient has tried Humira for a period of at least 3 months; AND

2. Rheumatoid Arthritis
   a) Patient has tried at least ONE conventional synthetic DMARD (such as methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine) for a period of at least 3 months.

3. Systemic Juvenile Idiopathic Arthritis
   a) Patient has tried a nonsteroidal anti-inflammatory drug (NSAID);

4. Giant Cell Arteritis
   a) Patient has tried one systemic corticosteroid.

5. Polymyalgia Rheumatica
   a) Patient has tried one systemic corticosteroid; AND
   b) Patient has evidence of large vessel vasculitis by angiography or imaging (e.g. MRI, PET/CT).

6. Cytokine Release Syndrome
   a) Patient is experiencing a severe or life-threatening T-cell induced reaction, AND
   b) The IV formulation of Actemra is being used for treatment, AND
   c) A maximum of 4 doses is requested.

Note: Authorization for indications, dosing, or a route of administration 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 appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ Polyarticular juvenile idiopathic arthritis
- ☐ Rheumatoid arthritis
- ☐ Systemic juvenile idiopathic arthritis
- ☐ Giant cell arteritis
- ☐ Polymyalgia rheumatica
- ☐ Cytokine Release Syndrome (CRS)
- ☐ Other – the patient's condition is: _____

  Rationale for use: _____

Which of the following has the patient had a documented therapeutic trial with?

- ☐ NSAID Dates of therapy: _____
- ☐ Methotrexate Dates of therapy: _____
- ☐ Leflunomide Dates of therapy: _____
- ☐ Hydroxychloroquine Dates of therapy: _____
- ☐ Sulfasalazine Dates of therapy: _____
- ☐ Enbrel Dates of therapy: _____
- ☐ Humira Dates of therapy: _____
- ☐ Other Drug: _____ Dates of therapy: _____

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

- ☐ Yes Date: _____
- ☐ No, rationale for use: _____

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C. Will the patient be receiving other biologic therapy in combination with Actemra?
☐ No ☐ Yes, rationale for use: _____

D. Does the patient have moderate to severe heart failure?
☐ No ☐ Yes, rationale for use: _____

E. If Actemra is being requested to treatment Polymyalgia Rheumatica, documentation that the patient has evidence of large vessel vasculitis must be submitted to Priority Health.

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Last reviewed 01/2019