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Actemra (tocilizumab)
Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-512-9004
Provider Help Desk 1-800-454-3730

1. Patient information	**2. Physician information**
Patient name: _____	Prescribing physician: _____
Patient ID #: _____	Physician address: _____
Patient DOB: _____	Physician phone #: _____
Date of Rx: _____	Physician fax #: _____
Patient phone #: _____	Physician specialty: _____
Patient email address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician email address: _____

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
Actemra (tocilizumab)	_____	_____	Specify: _____
7. Diagnosis: _____			

8. Approval criteria: (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

□ Yes	□ No	Patient has been screened for hepatitis B and C [PLEASE NOTE: patients with active hepatitis B will not be considered for coverage] Patients with evidence of active Hepatitis B infection (Hepatitis surface antigen positive > 6 months) must have documentation they are receiving or have received effective antiviral treatment
□ Yes	□ No	Patient has been screened for hepatitis B and C [PLEASE NOTE: patients with active hepatitis B will not be considered for coverage]
□ Yes	□ No	Patient has a diagnosis of congestive heart failure (CHF) that is New York Heart Association (NYHA) class lll or lV and with an ejection fraction of 50% or less
□ Yes	□ No	Patient has been screened for latent TB infection [PLEASE NOTE: patients with latent TB will only be considered after one month of TB treatment and patients with active TB will only be considered upon completion of TB Treatment]
□ Yes	□ No	The requested medication will be given concurrently with live vaccines
□ Yes	□ No	Patient has had previous trials and therapy failures with TWO preferred biological agents or there is

clinical evidence that the use of these agents would be medically contraindicated.
(the preferred biological agents are: Humira, Enbrel, Cosentyx)
*** DOCUMENTATION must be submitted which includes the following information:** that the patient had previous trials and therapy failures with two preferred biologicals or there is clinical evidence that the use of these agents would be medically contraindicated. Documentation may include, but is not limited to, chart notes, prescription claims records, prescription receipts, and laboratory data.

Rheumatoid Arthritis (RA):

□ Yes □ No Patient has a diagnosis of rheumatoid arthritis (RA)

□ Yes □ No Patient had a trial, and inadequate response to, TWO preferred disease modifying anti-rheumatic drugs (DMARDs) used concurrently. [PLEASE NOTE: The combination must include methotrexate plus another preferred oral DMARD (hydroxycholoroquine, sulfasalazine, or leflunomide,)]

□ Yes □ No Patient had a clinical evidence that the use of methotrexate and/or the preferred medications would be medically contraindicated for this patient. [PLEASE NOTE: The preferred DMARDs are hydroxycholoroquine, sulfasalazine, and leflunomide]

□ Yes □ No Patient had an unsuccessful methotrexate trial

□ Yes □ No There evidence of severe disease documented by radiographic erosions

*** DOCUMENTATION must be submitted which includes the following information:** that there is a clinical evidence that the use of the preferred oral DMARD, methotrexate would be medically contraindicated for this patient, AND if there is a contraindication to methotrexate then also the clinical reason this patient would not be able to use leflunomide or sulfasalazine instead or there is clinical evidence that the use of hydroxychloroquine is medically contraindicated, or there is evidence of severe disease documented by radiographic erosions. Documentation may include but is not limited to, chart notes, prescriptions claims records, prescription receipts, and laboratory data.

9. Physician signature

_____ _____

Prescriber or authorized signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

Important note: You are not permitted to use or disclose Protected Health Information about individuals who you are not treating or are not enrolled to your practice. This applies to Protected Health Information accessible in any online tool, sent in any medium including mail, email, fax or other electronic transmission.