



# MEDICARE FORM

## Actemra® (tocilizumab) Injectable Medication Precertification Request

Page 1 of 3

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

Virginia (HMO D-SNP):  
FAX: 1-833-280-5224  
PHONE: 1-855-463-0933

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 #:	Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
Group #:	If yes, provide ID#: _____ Carrier Name: _____
Insured:	Insured:

### C. PRESCRIBER INFORMATION

First Name:		Last Name:		(Check One): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A.	
Address:			City:		State: ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Office Contact Name:				Phone:	

### D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

<b>Place of Administration:</b> <input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Outpatient Infusion Center      Phone: _____ Center Name: _____ <input type="checkbox"/> Home Infusion Center      Phone: _____ Agency Name: _____ <input type="checkbox"/> Administration code(s) (CPT): _____ Address: _____  Please explain if there are any medical reason(s) why the patient cannot self-inject the requested drug: _____ _____ _____	<b>Dispensing Provider/Pharmacy:</b> <input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Mail Order <input type="checkbox"/> Other: _____ Name: _____ Address: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____
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### E. PRODUCT INFORMATION

Request is for: <input type="checkbox"/> Actemra (tocilizumab) IV <input type="checkbox"/> Actemra (tocilizumab) SC
HCPCS Code: _____ Dose: _____
Frequency: _____

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

Primary ICD Code: _____	<input type="checkbox"/> Other ICD Code: _____
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### 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. Remicade, Renflexis, and Simponi Aria are preferred for MA plans. Enbrel, Humira, Rinvoq, and Xeljanz 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, intolerance, or contraindication to any of the following? (select all that apply)  
 Remicade (infliximab)  Renflexis (infliximab-abda)  Simponi Aria (golimumab)

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

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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**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)

- Remicade (infliximab)
- Renflexis (infliximab-abda)
- 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)
- Rinvoq (upadacitinib)
- Xeljanz (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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**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.