Actemra® (tocilizumab) Injectable Medication Precertification Request

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

Aetna Precertification Notification
Phone: 1-866-752-7021 (TTY: 711)
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Please Use Medicare Request Form

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 #: _____
Group #: _____
Insured:

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured:

Medicare: ☐ Yes ☐ No If yes, provide ID #:

Medicaid: ☐ Yes ☐ No If yes, provide ID #:

C. PRESCRIBER INFORMATION

First Name:		Last Name:		*(Check One)*: ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.	
Address:			City:	State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	

Specialty *(Check one)*: ☐ **Oncologist** ☐ **Rheumatologist** ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for: ☐ Actemra (tocilizumab) ☐ **Dose:** _____ **Frequency:** _____

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

Primary ICD Code: _____ ☐ Other ICD Code: _____

G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

For ALL Requests (clinical documentation required):

☐ Yes ☐ No Is this infusion request in an outpatient hospital setting?

→ ☐ Yes ☐ No Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (e.g., acetaminophen, steroids, diphenhydramine, fluids, other pre-medications) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion?

☐ Yes ☐ No Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting?

☐ Yes ☐ No Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver?

→ Please provide a description of the behavioral issue or impairment: _____

☐ Yes ☐ No Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?

→ Please provide a description of the condition: ☐ Cardiopulmonary: _____
☐ Respiratory: _____
☐ Renal: _____
☐ Other: _____

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G. CLINICAL INFORMATION *(continued)* - Required clinical information must be completed in its entirety for all precertification requests.

☐ Yes ☐ No Will the requested drug be used in combination with any other biologic (e.g., Humira) or targeted synthetic drug (e.g., Olumiant, Otezla, Xeljanz)?

☐ Yes ☐ No Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Olumiant, Xeljanz) associated with an increased risk of tuberculosis?

→ ☐ Yes ☐ No Has the patient had a tuberculosis (TB) test (e.g., tuberculosis skin test [PPD], interferon-release assay [IGRA], chest x-ray) within 6 months of initiating therapy?

(Check all that apply): ☐ PPD test ☐ interferon-gamma assay (IGRA) ☐ chest x-ray

→ Please enter the results of the tuberculosis (TB) test: ☐ positive ☐ negative ☐ unknown

If positive, please indicate which applies to the patient:

☐ latent TB and treatment for latent TB has been initiated
☐ latent TB and treatment for latent TB has been completed
☐ latent TB and treatment for latent TB has not been initiated
☐ active TB

For Initiation Requests (clinical documentation required):

Acute graft versus host disease

☐ Yes ☐ No Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?

☐ Yes ☐ No Has the patient experienced an inadequate response to systemic corticosteroids?

☐ Yes ☐ No Does the patient have an intolerance or contraindication to corticosteroids?

Castleman's disease (CD)- Multicentric

☐ Yes ☐ No Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?

☐ Yes ☐ No Is the disease relapsed/refractory or progressive?

☐ Yes ☐ No Will the requested drug be used as second-line therapy?

☐ Yes ☐ No Will the requested drug be used as monotherapy?

Castleman's disease (CD)- Unicentric

☐ Yes ☐ No Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?

☐ Yes ☐ No Has the patient been tested for human immunodeficiency virus (HIV)?

→ Please indicate the results of the HIV test: ☐ positive ☐ negative ☐ unknown

☐ Yes ☐ No Has the patient been tested for herpesvirus-8?

→ Please indicate the results of the herpesvirus-8 test: ☐ positive ☐ negative ☐ unknown

☐ Yes ☐ No Is the disease relapsed or refractory?

☐ Yes ☐ No Will the requested drug be used a second-line therapy?

☐ Yes ☐ No Will the requested drug be used as a monotherapy?

Cytokine release syndrome

☐ Yes ☐ No Has the patient been diagnosed with chimeric antigen receptor (CAR) T cell-induced cytokine release syndrome (CRS)?

☐ Yes ☐ No Does the patient have refractory cytokine release syndrome (CRS) related to blinatumomab therapy?

Giant cell arteritis

☐ Yes ☐ No Has the diagnosis been confirmed by temporal artery biopsy or cross-sectional imaging?

→ ☐ Yes ☐ No Has the diagnosis been confirmed by acute-phase reactant elevation (i.e., high erythrocyte sedimentation rate [ESR] and/or high serum reactive protein [CRP])?

Oligoarticular juvenile idiopathic arthritis/Polyarticular juvenile idiopathic arthritis (pJIA)

☐ Yes ☐ No Has the patient been diagnosed with active articular juvenile idiopathic arthritis?

☐ Yes ☐ No Is the requested drug being prescribed by or in consultation with a rheumatologist?

☐ Yes ☐ No Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug indicated for active articular juvenile idiopathic arthritis?

→ ☐ Yes ☐ No Has the patient had an inadequate response to methotrexate or another conventional synthetic drug (e.g., leflunomide, sulfasalazine, hydroxychloroquine) administered at an adequate dose and duration?

→ ☐ Yes ☐ No Has the patient had an inadequate response to a trial of scheduled non-steroidal anti-inflammatory drugs (NSAIDs) and/or intra-articular glucocorticoids (e.g., triamcinolone hexacetonide)?

→ ☐ Yes ☐ No Does the patient have one of the following risk factors for poor outcome: a) involvement of ankle, wrist, hip, sacroiliac joint, and/or temporomandibular joint (TMJ), b) presence of erosive disease or enthesitis, c) delay in diagnosis, d) elevated levels of inflammation markers, or e) symmetric disease?

☐ Yes ☐ No Does the patient have any of the following risk factors for disease severity and potentially a more refractory disease course: a) positive rheumatoid factor, b) positive anti-cyclic citrullinated peptide antibodies, or c) pre- existing joint damage?

☐ Yes ☐ No Does the patient meet any of the following: a) high-risk joints are involved (e.g., cervical spine, wrist, or hip), b) high disease activity, or c) high risk for disabling joint disease?

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G. CLINICAL INFORMATION *(continued)* - Required clinical information must be completed in its entirety for all precertification requests.

Rheumatoid arthritis

☐ Yes ☐ No Has the patient been diagnosed with moderately to severely active rheumatoid arthritis (RA)?

☐ Yes ☐ No Is the requested drug being prescribed by or in consultation with a rheumatologist?

☐ Yes ☐ No Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Xeljanz) that is indicated for moderately to severely active rheumatoid arthritis?

→ ☐ Yes ☐ No Does the patient meet either of the following: a) the patient was tested for the rheumatoid factor (RF) biomarker and the RF biomarker test was positive, or b) the patient was tested for the anti-cyclic citrullinated peptide (anti-CCP) biomarker and the anti-CCP biomarker test was positive?

→ ☐ Yes ☐ No Has the patient been tested for all of the following biomarkers: a) rheumatoid factor (RF), b) anti-cyclic citrullinated peptide (anti-CCP), and c) C-reactive protein (CRP) and/or erythrocyte sedimentation rate (ESR)?

☐ Yes ☐ No Has the patient experienced an inadequate response after at least 3 months of treatment with methotrexate at a dose greater than or equal to 15 mg per week?

→ ☐ Yes ☐ No Has the patient experienced an intolerance to methotrexate?

→ ☐ Yes ☐ No Does the patient have a contraindication to methotrexate?

→ Please indicate the contraindication:

☐ History of intolerance or adverse event ☐ Renal impairment ☐ Hypersensitivity
☐ Blood dyscrasias (e.g., thrombocytopenia, leukopenia, significant anemia)
☐ Breastfeeding ☐ Elevated liver transaminases ☐ Myelodysplasia
☐ Interstitial pneumonitis or clinically significant pulmonary fibrosis
☐ Pregnancy or currently planning pregnancy ☐ Significant drug interaction
☐ Clinical diagnosis of alcohol use disorder, alcoholic liver disease or other chronic liver disease
☐ Other: _____

Please indicate the preferred alternatives for rheumatoid arthritis that have been ineffective, not tolerated, or are contraindicated: ☐ Inflectra ☐ Simponi Aria

Systemic juvenile idiopathic arthritis

☐ Yes ☐ No Has the patient been diagnosed with active systemic juvenile idiopathic arthritis (sJIA)?

☐ Yes ☐ No Has the patient ever received (including current utilizers) a biologic (e.g., Humira) indicated for active systemic juvenile idiopathic arthritis?

→ ☐ Yes ☐ No Has the patient experienced an inadequate response to ANY of the following?

→ Please select: ☐ At least 1-month trial of NSAIDs ☐ At least 2 weeks of treatment with corticosteroids (e.g., prednisone, methylprednisolone) ☐ At least 3 months of treatment with methotrexate ☐ At least 3 months of treatment with leflunomide

For Continuation Requests (clinical documentation required for all requests):

☐ Yes ☐ No Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?

Acute graft versus host disease

☐ Yes ☐ No Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?

Castleman's disease (CD)- Multicentric or Unicentric

☐ Yes ☐ No Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?

☐ Yes ☐ No Is there evidence of unacceptable toxicity or disease progression on the current regimen?

Giant cell arteritis

☐ Yes ☐ No Has the patient achieved or maintained positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug?

→ Please indicate which of the following the patient has experienced an improvement in from baseline:

☐ Headaches ☐ Scalp tenderness ☐ Tenderness and/or thickening of superficial temporal arteries
☐ Constitutional symptoms (e.g., weight loss, fever, fatigue, night sweats ☐ Jaw and/or tongue claudication
☐ Acute visual symptoms (e.g., amaurosis fugax, acute visual loss, diplopia) ☐ Limb claudication
☐ Symptoms of polymyalgia rheumatica (e.g., shoulder and/or hip girdle pain) ☐ None of the above

Oligoarticular juvenile idiopathic arthritis/Polyarticular juvenile idiopathic arthritis (pJIA)

☐ Yes ☐ No Has the patient achieved or maintained positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug?

→ Please indicate which of the following the patient has experienced an improvement from baseline:

☐ Number of joints with active arthritis (e.g., swelling, pain, limitation of motion) ☐ Number of joints with limitation of movement
☐ Functional ability ☐ None of the above

Rheumatoid arthritis

☐ Yes ☐ No Has the patient achieved or maintained positive clinical response since starting treatment with the requested drug?

→ ☐ Yes ☐ No Has the patient experienced substantial disease activity improvement (e.g., at least 20% from baseline) in tender joint count, swollen joint count, pain, or disability?

→ Please indicate the percent of substantial disease activity improvement in tender joint count, swollen joint count, pain, or disability: _____ %

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☐ Yes ☐ No Is the prescriber increasing the dose or dose frequency?
→ Please select: ☐ Increasing dose ☐ Increasing dose frequency ☐ Decreasing dose

☐ Yes ☐ No Does the patient require an increased dose or dose frequency due to lack of clinical response at the current dose?

Systemic juvenile idiopathic arthritis

☐ Yes ☐ No Has the patient achieved or maintained positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug?

→ Please indicate which of the following the patient has experienced an improvement from baseline:
☐ Number of joints with active arthritis (e.g., swelling, pain, limitation of motion) ☐ Number of joints with limitation of movement
☐ Functional ability ☐ Systemic symptoms (e.g., fevers, evanescent skin rashes) ☐ None of the above

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.