



MEDICARE FORM

Actemra® (tocilizumab) Injectable Medication Precertification Request

Page 1 of 3

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

For Medicare Advantage Part B:
Phone: **1-866-503-0857** (TTY: **711**)
FAX: **1-844-268-7263**

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:	
Provider Email:		Office Contact Name:		Phone:	

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration: <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: _____ City: _____ State: _____ ZIP: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____ NPI: _____ Please explain if there are any medical reason(s) why the patient cannot self-inject the requested drug: _____ _____ _____		Dispensing Provider/Pharmacy: <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: _____ City: _____ State: _____ ZIP: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____ NPI: _____	
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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. Inflectra, Remicade, Simponi Aria and unbranded infliximab are preferred for MA plans. Enbrel, Humira, Kevzara, Rinvoq, and Xeljanz/Xeljanz XR 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 and failure, intolerance, or contraindication to any of the following? (select all that apply)

Inflectra (infliximab-dyyb) Remicade (infliximab) Simponi Aria (golimumab) Unbranded infliximab

Yes No Has the patient had a trial and failure, intolerance, or contraindication to any of the following? (select all that apply)

Enbrel (etanercept) Humira (adalimumab) Kevzara (sarilumab) Rinvoq (upadacitinib) Xeljanz/Xeljanz XR (tofacitinib)

Continued on next page



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Page 2 of 3

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For other lines of business: Please use other form.

Note: Actemra is non-preferred. Preferred products may vary based on indication. See section G.

Patient First Name Patient Last Name Patient Phone Patient DOB

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)

- Inflectra (infliximab-dyyb) Remicade (infliximab) Simponi Aria (golimumab) Unbranded infliximab

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) Kevzara (sarilumab) Rinvoq (upadacitinib) Xeljanz/Xeljanz XR (tofacitinib)

Castleman's disease (CD)

- Is this request for IV formulation? Will Actemra (tocilizumab) be used as a monotherapy? Does the patient have unicentric CD? Does the patient have documented multicentric CD? Has the disease progressed following treatment of relapsed/refractory or progressive disease?

Cytokine release syndrome

- Is this request for IV formulation? 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

- Is this request for subcutaneous formulation? Has the patient had a temporal artery biopsy or cross-sectional imaging? Does the patient have acute-phase reactant elevation (i.e., high erythrocyte sedimentation rate [ESR])? 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? What is the severity of the patient's disease? Is there evidence that the disease is active?

Rheumatoid Arthritis

- Is this request for IV formulation or subcutaneous formulation? Please indicate the severity of the patient's rheumatoid arthritis: Was treatment with methotrexate ineffective? Was treatment with another conventional DMARD (other than methotrexate) ineffective?

Systemic juvenile idiopathic arthritis

- Is this request for IV formulation or subcutaneous formulation? Is there evidence that the disease is active? Does the patient's initial symptoms include high fevers and painful polyarthritis? Was treatment with non-steroidal anti-inflammatory (NSAID) monotherapy ineffective? Provide the name of the NSAID:

Continued on next page



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Page 3 of 3

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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):

- Is this continuation request a result of the patient receiving samples of Actemra (tocilizumab)?
Will Actemra (tocilizumab) be used concomitantly with apremilast, tofacitinib, or other biologic DMARDs (e.g., adalimumab, infliximab)?
Is there clinical documentation supporting disease stability?
Is there clinical documentation supporting disease improvement?
Does the patient have any risk factors for TB?
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):

- Has the patient received Actemra (tocilizumab) within the past 6 months?
Does the patient have a documented severe and/or potentially life-threatening adverse event that occurred during or following the previous infusion?
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.