ATRIO HEALTH PLANS

Actemra

Actemra (tocilizumab) J3262

Prior Authorization Request
Medicare Part B Form

*Instructions: * Indicates required information – Form may be returned if required information is not provided. Please fax this request to the appropriate fax number listed at the bottom of the page.*

☐	**Standard Request– (72 Hours)**	☐	**Urgent Request** (standard time frame could place the member's life, health or ability in serious jeopardy)
	Date Requested _____		
	Requestor _____ Clinic name: _____ Phone / Fax		

MEMBER INFORMATION

*Name:_____ *ID#:_____ *DOB:_____

PRESCRIBER INFORMATION

*Name:_____ ☐MD ☐FNP ☐DO ☐NP ☐PA *Phone:_____

*Address:_____ *Fax:_____

DISPENSING PROVIDER / ADMINISTRATION INFORMATION

*Name:_____ Phone:_____

*Address:_____ Fax:_____

PROCEDURE / PRODUCT INFORMATION

HCPC Code	Name of Drug	Dose (Wt: _____ kg Ht:_____)	Frequency	End Date if known

☐ **Self-administered** ☐ **Provider-administered** ☐ **Home Infusion**

☐Chart notes attached. **Other important information:**_____

Diagnosis: ICD10: _____ **Description**: _____

☐ Provider attests the diagnosis provided is an FDA-Approved indication for this drug

CLINICAL INFORMATION

☐ **New Start or Initial Request: (Clinical documentation required for all requests)**

☐ **Provider has reviewed the attached "Criteria for Approval" and attests the member meets ALL required PA criteria.**

If not, please provide **clinical rationale** for formulary exception: _____

_____

☐ **Continuation Requests: (Clinical documentation required for all requests)**

☐ Patient had an adequate response or significant improvement while on this medication.

If not, please provide clinical rationale for continuing this medication: _____

_____

ACKNOWLEDGEMENT

Request 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. **THIS AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT.** PAYMENT IS BASED ON BENEFITS IN EFFECT AT THE TIME OF SERVICE, MEMBER ELIGIBILITY AND MEDICAL NECESSITY.

Prior Authorization Group – Actemra PA

Drug Name(s):
ACTEMRA **TOCILIZUMAB**

Criteria for approval of Prior Authorization Drug:
1. Prescribed for an approved FDA diagnosis (as listed below):
2. Member does not have any clinically relevant contraindications, or CMS/Plan exclusions, to the requested drug.

- If the member meets all these criteria, they may be approved by the Plan for the requested drug.
- Quantity limits and Tiering will be determined by the Plan.

Exclusion Criteria:
N/A

Prescriber Restrictions:
N/A

Coverage Duration:
Initial approval will be for 6 months. Continuation may be approved for up to 12 months.

FDA Indications:
Actemra
- COVID-19, In hospitalized patients receiving systemic corticosteroids and require supplementation oxygen, non-invasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation (ECMO)
- Cytokine release syndrome, Chimeric antigen receptor T-cell induced, severe or life threatening disease
- Juvenile idiopathic arthritis, Polyarticular
- Lung disease with systemic sclerosis
- Rheumatoid arthritis (Moderate to Severe), In patients who had an inadequate response to disease modifying antirheumatic therapy
- Systemic onset juvenile chronic arthritis
- Temporal arteritis

Off-Label Uses:
- Renal transplant rejection, Chronic, active antibody-mediated rejection
- Rheumatoid arthritis (Moderate to Severe), With no previous treatment failure
- Thyroid eye disease (Moderate to Severe), Active

Age Restrictions:
2 years and older

Other Clinical Considerations:
Black Box Warning: (IV; powder for solution)
atients treated with tocilizumab are at increased risk for infections, some progressing to serious infections leading to hospitalization or death. These infections have included bacterial infection, tuberculosis, invasive fungal, or other opportunistic infections. Evaluate for latent tuberculosis and treat if necessary prior to initiation of therapy. Monitor patients receiving tocilizumab for signs and symptoms of infection, including tuberculosis, even if initial latent tuberculosis test is negative

Resources:

https://www.micromedexsolutions.com/micromedex2/librarian/CS/254316/ND_PR/evidencexpert/ND_P/evidencexpert/DUPLICATIONSHIELDSYNC/251033/ND_PG/evidencexpert/ND_B/evidencexpert/ND_AppProduct/evidencexpert/ND_T/evidencexpert/PFActionId/evidencexpert.DoIntegratedSearch?SearchTerm=Tocilizumab&fromInterSaltBase=true&UserMdxSearchTerm=%24userMdxSearchTerm&false=null&=null#