Actemra® (tocilizumab) Injectable Medication Precertification Request

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

Aetna Precertification Notification
Phone: 1-855-240-0535
FAX: 1-877-269-9916
IV Formulation only:
Phone: 1-866-752-7021
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) IV ☐ Actemra (tocilizumab) SC **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 IV Formulation Requests Only (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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Fax: 1-888-267-3277

For Medicare Advantage Part B:
Please Use Medicare Request Form

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.

For ALL Requests (clinical documentation required):

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

☐ Yes ☐ No Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic DMARD (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, Does the patient have latent or active tuberculosis TB? ☐ latent ☐ active ☐ unknown

If latent tuberculosis TB, ☐ Yes ☐ No Has treatment for latent tuberculosis (TB) infection been initiated or completed?

→ Please select: ☐ treatment initiated ☐ treatment completed

→ ☐ Yes ☐ No Does the patient have risk factors for tuberculosis (TB) (e.g., persons with close contact to people with infectious TB disease; persons who have recently immigrated from areas of the world with high rates of TB [e.g., Africa, Asia, Eastern Europe, Latin America, Russia]; children less than 5 years of age who have a positive TB test; groups with high rates of TB transmission [e.g., homeless persons, injection drug users, persons with HIV infection], or persons who work or reside with people who are at an increased risk for active TB [e.g., hospitals, long-term care facilities, correctional facilities, homeless shelters])?

→ ☐ Yes ☐ No Has the patient been tested for tuberculosis (TB) within the previous 12 months?

→ (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, Does the patient have latent or active tuberculosis (TB)? ☐ latent ☐ active ☐ unknown

If latent tuberculosis TB, ☐ Yes ☐ No Has treatment for latent tuberculosis (TB) infection been initiated or completed?

→ Please select: ☐ treatment initiated ☐ treatment completed

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])?

Immunotherapy-related inflammatory arthritis

☐ 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 severe or refractory?

☐ Yes ☐ No Has the patient tried and not responded to corticosteroids and anti-inflammatory agents?

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

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

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

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

→ ☐ Yes ☐ No Has the patient had an inadequate response to methotrexate or another non-biologic DMARD administered at an adequate dose and duration?

→ ☐ Yes ☐ No Does the patient have any of the following risk factors: 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?

☐ Yes ☐ No Has the patient had an ineffective response, contraindication, or intolerance to Enbrel?

☐ Yes ☐ No Has the patient had an ineffective response, contraindication, or intolerance to Humira?

Rheumatoid arthritis

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

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

→ ☐ Yes ☐ No Has the patient been tested for the rheumatoid factor (RF) biomarker?
Please indicate the test result: ☐ positive ☐ negative ☐ not completed

☐ Yes ☐ No Has the patient been tested for the anti-cyclic citrullinated peptide (anti-CCP) biomarker?
Please indicate the test result: ☐ positive ☐ negative ☐ not completed

☐ Yes ☐ No Has the patient been tested for the C-reactive protein (CRP) and/or erythrocyte sedimentation rate (ESR) biomarker(s)?
Please indicate the test result: ☐ positive ☐ negative ☐ not completed

☐ Yes ☐ No Has the patient been tested for the erythrocyte sedimentation rate (ESR) biomarker?
Please indicate the test result: ☐ positive ☐ negative ☐ not completed

☐ 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 20mg 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: _____

For Subcutaneous Injection:
Please indicate the preferred alternatives for rheumatoid arthritis that have been ineffective, not tolerated, or are contraindicated:
☐ Enbrel ☐ Humira ☐ Kevzara ☐ Orencia ☐ Rinvoq ☐ Xeljanz/Xeljanz XR

For Intravenous Injection:
Please indicate the preferred alternatives for rheumatoid arthritis that have been ineffective, not tolerated, or are contraindicated:
☐ Enbrel ☐ Humira ☐ Kevzara ☐ Orencia ☐ Remicade ☐ Rinvoq ☐ Simponi Aria ☐ Xeljanz/Xeljanz XR

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

Systemic sclerosis-associated interstitial lung disease

☐ Yes ☐ No Has the diagnosis been confirmed by a high-resolution computed tomography (HRCT) study of the chest?

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G. CLINICAL INFORMATION - Required clinical information must be completed for ALL precertification requests.

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 or Immunotherapy-related inflammatory arthritis:

☐ 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?

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

☐ 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.