aetna®

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: 1-866-503-0857
Fax: 1-888-267-3277
For Medicare Advantage Part B:
FAX: 1-844-268-7263

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? ☐ Yes ☐ No
Group #: _____	If yes, provide ID#: _____ Carrier Name: _____
Insured:	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):* ☐ **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 ☐ Mail Order
☐ 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 ALL 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)?

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?

Continued on next page

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

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?

☐ Yes ☐ No Was treatment with Enbrel (etanercept) ineffective, not tolerated, or contraindicated? ☐ ineffective ☐ not tolerated ☐ contraindicated

→ Please indicate the length of the Enbrel (etanercept) treatment: ☐ Less than 30 days ☐ 30-60 days ☐ 60-90 days ☐ 90 days or more

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?

Please indicate how many of the following medications have been ineffective, not tolerated, or contraindicated: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

Enbrel (etanercept), Inflectra (infliximab-dyyb), Remicade (infliximab), Renflexis (infliximab-abda), Simponi (golimumab), Simponi Aria (golimumab), Xeljanz/Xeljanz XR (tofacitinib citrate)

Please indicate the ***first*** medication that has been ineffective, not tolerated, or contraindicated:

☐ Enbrel (etanercept) ☐ Inflectra (infliximab-dyyb) ☐ Remicade (infliximab) ☐ Renflexis (infliximab-abda) ☐ Simponi (golimumab)
☐ Simponi Aria (golimumab) ☐ Xeljanz/Xeljanz XR (tofacitinib citrate)

Was treatment ineffective, not tolerated, or contraindicated? ☐ ineffective ☐ not tolerated ☐ contraindicated

Please indicate how long the first medication trial was: ☐ Less than 30 days ☐ 30-60 days ☐ 60-90 days ☐ 90 days or more

Please indicate the ***second*** medication that has been ineffective, not tolerated, or contraindicated:

☐ Enbrel (etanercept) ☐ Inflectra (infliximab-dyyb) ☐ Remicade (infliximab) ☐ Renflexis (infliximab-abda) ☐ Simponi (golimumab)
☐ Simponi Aria (golimumab) ☐ Xeljanz/Xeljanz XR (tofacitinib citrate)

Was treatment ineffective, not tolerated, or contraindicated? ☐ ineffective ☐ not tolerated ☐ contraindicated

Please indicate how long the second medication trial was: ☐ Less than 30 days ☐ 30-60 days ☐ 60-90 days ☐ 90 days or more

Please indicate the ***third*** medication that has been ineffective, not tolerated, or contraindicated:

☐ Enbrel (etanercept) ☐ Inflectra (infliximab-dyyb) ☐ Remicade (infliximab) ☐ Renflexis (infliximab-abda) ☐ Simponi (golimumab)
☐ Simponi Aria (golimumab) ☐ Xeljanz/Xeljanz XR (tofacitinib citrate)

Was treatment ineffective, not tolerated, or contraindicated? ☐ ineffective ☐ not tolerated ☐ contraindicated

Please indicate how long the third medication trial was: ☐ Less than 30 days ☐ 30-60 days ☐ 60-90 days ☐ 90 days or more

☐ Yes ☐ No Was treatment with methotrexate ineffective, not tolerated, or contraindicated? ☐ ineffective ☐ not tolerated ☐ contraindicated

→ Please indicate the length of the methotrexate therapy: ☐ Less than 30 days ☐ 30-60 days ☐ 60-90 days ☐ 90 days or more

☐ Yes ☐ No Was treatment with another conventional DMARD (i.e., azathioprine, hydroxychloroquine, leflunomide, sulfasalazine) ineffective?

→ Provide the name of the DMARD:_____

Please indicate the length of the DMARD treatment: ☐ Less than 30 days ☐ 30-60 days ☐ 60-90 days ☐ 90 days or more

Systemic juvenile idiopathic arthritis

☐ Yes ☐ No Is this request for IV 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: _____

Please indicate how long the NSAID trial was: ☐ Less than 30 days ☐ 30-60 days ☐ 60-90 days ☐ 90 days or more

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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)? (Sampling of Actemra (tocilizumab) does not guarantee coverage under the provisions of the pharmacy benefit).

☐ 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 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.