



Actemra® (tocilizumab) Injectable Medication Precertification Request

Page 1 of 4

(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

Please indicate: Start of treatment: Start date ____/____/____
 Continuation of therapy: Date of last treatment ____/____/____

For Medicare Advantage Part B:
Please Use Medicare Request Form

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: _____	
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____		Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____	

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:
Specialty (Check one): <input type="checkbox"/> Oncologist <input type="checkbox"/> Rheumatologist <input type="checkbox"/> Other: _____					

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: _____		Dispensing Provider/Pharmacy: Patient Selected choice <input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> 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: _____

Continued on next page



Actemra® (tocilizumab) Injectable Medication Precertification Request

Page 2 of 4

(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:

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**, 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])?

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?

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?

Continued on next page



Actemra® (tocilizumab) Injectable Medication Precertification Request

Page 3 of 4

(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:

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.

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 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: _____

For Subcutaneous Injection:

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

- Enbrel Humira Kevzara 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 Inflectra 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?

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

Continued on next page



Actemra® (tocilizumab) Injectable Medication Precertification Request

Page 4 of 4

(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

Patient First Name	Patient Last Name	Patient Phone	Patient DOB
--------------------	-------------------	---------------	-------------

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

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.