

ACTEMRA (tocilizumab)

SPECIALTY PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Patient Information	
Name:	Member ID #:
Group Name:	Date of Birth:
Diagnosis:	Diagnosis Code:

Provider Information	
Prescriber's Name:	Prescriber's DEA #:
Phone:	Fax:
Office Address:	

Complete and review information, sign and date. Fax signed form to Caremark Specialty's prior authorization department at 1-866-249-6155. The Caremark fax machine is located in a secure location as required by HIPAA regulations. On behalf of the member's health plan, Caremark assists in the administration of the prior authorization program. Caremark is an independent company that administers prescription drug benefits.

Providers may call Caremark at 1-866-814-5506 with any questions concerning prior authorization procedures. For questions related to the patient's eligibility, drug copay or delivery, providers and members should call Caremark Specialty Customer Care at 1-866-513-5214 with any questions. Members may also call their health plan at the number indicated on their Member ID cards.

Please check or circle the appropriate answer for each applicable question (Y for Yes, N for No).

1. What drug is being prescribed? Actemra
2. Will the prescribed drug be used in combination with other biologic medication(s) e.g., Cimzia, Enbrel, Humira, Kineret, Orencia, Remicade, Rituxan, Simponi? Y N
3. What is the **primary** diagnosis? Adult Rheumatoid Arthritis
 Other (specify): _____
4. Prior to initiating therapy, has the patient been screened for latent tuberculosis (TB) infection with either a TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB)? Y N
5. Was the latent TB test Positive or Negative? Positive Negative
[If answer is negative, skip to question 8.] Y N
6. If positive, has active Tuberculosis (TB) been ruled out? Y N
7. Is the patient currently receiving or completed treatment for latent TB? Y N
8. Is patient at risk for HBV (Hepatitis B Virus) infection? Y N

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[If the answer is no, skip to question 10.]

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| 9. Prior to initiating therapy, has HBV infection been ruled out or treatment initiated? | Y | N |
| 10. Does patient have other active infection (chronic or localized)? | Y | N |
| 11. Has the patient tried or had an insufficient response to a Tumor Necrosis Factor (TNF) inhibitor or is the use of a TNF inhibitor contraindicated? | Y | N |
| 12. Is patient currently receiving Actemra for rheumatoid arthritis (RA)? | Y | N |

[If the answer is yes, skip to question 18.]

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| 13. Is the patient currently on a Biologic Response Modifier (BRM), e.g. Cimzia, Enbrel, Humira, Kineret, Orencia, Remicade, Rituxan, or Simponi? | Y | N |
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[If the answer is yes, skip to question 19.]

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| 14. Has patient tried and had an insufficient response to a non-biologic Disease Modifying Anti-Rheumatic Drug (DMARD)? | Y | N |
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If no, please document clinical reason for not trying a DMARD.

If yes, please document the DMARD and the length of therapy that the patient has tried or had insufficient response to.

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| 15. Was the patient compliant to therapy? | Y | N |
| 16. Has dose/route been optimized without adequate response? | Y | N |
| 17. Has the patient's RA improved on Actemra? | Y | N |
| 18. If no, what is the reason for lack of improvement? | | |
| 19. Please document current BRM and length of therapy. | | |

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| 20. Will current BRM be discontinued if Actemra is approved? | Y | N |
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Comments:

I affirm that the information given on this form is accurate as of this date.

Prescriber (or Authorized) Signature and Date::