

ACTEMRA (tocilizumab) (non-preferred) PRIOR AUTHORIZATION FORM

Cytokine and CAM Antagonists and Quantity Limits/Daily Dose Limits prior authorization guidelines are accessible on the Department's Pharmacy Services website at <http://www.dhs.pa.gov/provider/pharmacyservices/index.htm>.

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info	Total # of pages: _____	
<input type="checkbox"/> Renewal request	(PA#: _____)	Prescriber name: _____	
Name of office contact: _____		Specialty: _____	
Contact's phone number: _____		State license #: _____	
LTC facility contact/phone: _____		NPI: _____	MA Provider ID#: _____
RECIPIENT INFORMATION		Street address: _____	
Recipient Name: _____		Suite #: _____	City/state/zip: _____
Recipient ID#: _____	DOB: _____	Phone: _____	Fax: _____

CLINICAL INFORMATION

Product requested:	<input type="checkbox"/> Actemra IV 80 mg/4 ml vial	<input type="checkbox"/> Actemra IV 400 mg/20 ml vial
	<input type="checkbox"/> Actemra IV 200 mg/10 ml vial	<input type="checkbox"/> Actemra SQ 162 mg/0.9 ml syringe
Directions: _____	Quantity: _____	Refills: _____
Diagnosis (<i>submit documentation</i>): _____		Recipient's weight: _____ lbs/kg
		Diagnosis code (<i>required</i>): _____

ALL requests

1. **Specialty Pharmacy Drug Program:** What Specialty Pharmacy will be used? Diplomat Specialty Walgreens Specialty
2. Check all that apply to the Recipient and *submit documentation for each*.
 - screened for hepatitis B (antibody and/or surface antigen)
 - screened for tuberculosis
 - up-to-date with all age-appropriate immunizations (if < 21 years of age, in accordance with EPSDT guidelines)

INITIAL requests – complete questions applicable to Recipient's diagnosis

3. **All diagnoses:** Does the Recipient have recent results of the following lab tests?

<input type="checkbox"/> liver function tests (LFTs)	<input type="checkbox"/> CBC with differential	<input type="checkbox"/> Yes	<i>Submit documentation of results.</i>
		<input type="checkbox"/> No	<i>results.</i>
4. **Systemic juvenile idiopathic arthritis:** submit form to Pharmacy Services.
5. **Rheumatoid arthritis or juvenile idiopathic arthritis:** Does the Recipient have a history of trial and failure, contraindication, or intolerance of at least 3 months of treatment with methotrexate or another DMARD?

<input type="checkbox"/> Yes	<i>Submit documentation of all medications tried and outcomes.</i>
<input type="checkbox"/> No	<i>outcomes.</i>
6. **Rheumatoid arthritis or juvenile idiopathic arthritis :** Does the Recipient have a history of trial and failure, contraindication, or intolerance of the preferred agents? *Check all that apply.*

<input type="checkbox"/> Enbrel	<input type="checkbox"/> Humira	<input type="checkbox"/> Yes	<i>Submit documentation of all medications tried and outcomes.</i>
		<input type="checkbox"/> No	<i>outcomes.</i>
7. **All other diagnoses:** Submit documentation supporting the use of the requested medication for the Recipient's diagnosis.

RENEWAL requests

1. Since starting Actemra, has the Recipient experienced a positive clinical response and/or improved level of functioning?

<input type="checkbox"/> Yes	<i>Submit documentation of clinical response.</i>
<input type="checkbox"/> No	<i>clinical response.</i>
2. Does the Recipient have recent results (since starting Actemra) of the following lab tests? *Check all that apply.*

<input type="checkbox"/> liver function tests (LFTs)	<input type="checkbox"/> CBC with differential	<input type="checkbox"/> Yes – <i>submit documentation of results.</i>	
		<input type="checkbox"/> No	

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature: _____	Date: _____
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