pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

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

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

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Product requested: Actemra injection	Route of administration: ☐IV ☐SC	Strength:
Directions:	Quantity: / Refills:	Beneficiary's weight: _____ lbs/kg
Diagnosis (*submit documentation*):		Diagnosis code (*required*):

Specialty Pharmacy Drug Program: Which specialty pharmacy will be used? ☐Diplomat Specialty ☐Walgreen's Specialty

INITIAL requests – complete questions applicable to beneficiary's diagnosis

1. ***All diagnoses***: Check all that apply to the beneficiary and *submit documentation for each*. ☐vaccinated for hepatitis B ☐screened for hepatitis B (surface antigen & core antibody) ☐has been using Actemra in the past 90 days ☐screened for tuberculosis ☐up-to-date with all age-appropriate immunizations		
2. ***All diagnoses***: Does the beneficiary have recent results of the following lab tests? ☐liver function tests (LFTs) ☐CBC with differential	☐Yes ☐No	*Submit documentation of results.*
3. ***Systemic juvenile idiopathic arthritis*** or ***cytokine release syndrome:*** Submit form & requested documentation to Pharmacy Services.		
4. ***Rheumatoid arthritis:*** Does the beneficiary have a history of trial and failure, contraindication, or intolerance of at least 3 months of treatment with methotrexate or another DMARD?	☐Yes ☐No	*Submit documentation of all medications tried and outcomes.*
5. ***Rheumatoid arthritis:*** Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred agents? *Check all that apply.* ☐Humira ☐Xeljanz	☐Yes ☐No	*Submit documentation of all medications tried and outcomes.*
6. ***Polyarticular juvenile idiopathic arthritis:*** Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred agent - **Humira**?	☐Yes ☐No	*Submit documentation of all medications tried and outcomes.*
7. ***Giant cell arteritis:*** Does the beneficiary have a history of trial and failure, contraindication, or intolerance to methotrexate?	☐Yes ☐No	*Submit documentation of all medications tried and outcomes.*
8. ***Giant cell arteritis:*** Will the beneficiary start treatment with Actemra while using a tapering dose of corticosteroids?	☐Yes ☐No	*Submit documentation of treatment regimen.*
9. ***For all other diagnoses,*** submit documentation supporting the use of Actemra for the beneficiary's diagnosis & other treatments tried.		

RENEWAL requests

1. Since starting Actemra, did the beneficiary experience a positive clinical response and/or improved level of functioning?	☐Yes ☐No	*Submit documentation of clinical response.*
2. Does the beneficiary have recent results (since starting Actemra) of the following lab tests? *Check all that apply.* ☐liver function tests (LFTs) ☐CBC with differential	☐Yes ☐No	*Submit documentation of results.*

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

Prescriber Signature:	**Date**: