Actemra (tolcizumab)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** DURATION OF THERAPY (SPECIFIC DATES):		**IF RENEWAL:** DATE THERAPY INITIATED:	

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MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
□ Moderate to severely active rheumatoid arthritis (RA) □ Polyarticular juvenile idiopathic arthritis (pJIA) □ Systemic juvenile Idiopathic arthritis (sJIA) □ Giant Cell Arteritis □ Other Diagnosis_____ICD-10 Code(s):_____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

For <u>all diagnosis</u>, answer the next 3 question.

Is the drug being prescribed by a rheumatologist? □ Yes □ No

Is the patient on concurrent treatment with another TNF inhibitor (i.e., Rituxan, Orencia, Remicade, Humira, Kineret, Enbrel, Simponi, Cimzia, etc.)? □ Yes □ No

For a <u>moderate to severe active rheumatoid arthritis</u> (RA), also answer the following:
Has the patient had a trial of methotrexate or another oral non-biologic disease modifying anti-rheumatic agent (DMARD) such as Imuran, Ridaura, Plaquenil, Sulfasalazine or Arava? □ Yes □ No

Is the patient unable to take the prerequisite non-biologic DMARD due to their chronic liver disease (such as chronic hepatitis, chronic alcohol abuse/alcoholism, fatty liver, nonalcoholic steatohepatitis/NASH, or elevated liver enzymes? □ Yes □ No

Has the patient tried and had an inadequate response to a three month trial of Enbrel? □ Yes □ No

Has the patient tried and had an inadequate response to a three month trial of Humira? □ Yes □ No

For <u>Polyarticular juvenile idiopathic arthritis(pJIA)</u> or <u>systemic juvenile idiopathic arthritis(sJIA</u>, also answer the following:
Does the patient have active polyarticular or systemic JIA? □ Yes □ No

Has the patient had an inadequate response to, intolerance to, or contraindication to one or more non-biologic DMARDs? □ Yes □ No

Is the patient age 2-17 years with axial spondyloarthropathy? □ Yes □ No

Has the patient tried and had an inadequate response to a three month trial of Enbrel? □ Yes □ No

Has the patient tried and had an inadequate response to a three month trial of Humira? □ Yes □ No

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For Giant Cell Arteritis:
Is the patient 50 years of age or older? □ Yes □ No

Is the patient currently on oral prednisone at a daily dose of between 20mg and 60mg per day? □ Yes □ No

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program
Attn: CP – 4201
P.O. Box 64811
St. Paul, MN 55164-0811