



**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](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:
<input type="checkbox"/> NEW THERAPY	<input type="checkbox"/> RENEWAL	IF RENEWAL: DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

*Continued on next page*





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MEMBER'S LAST NAME: \_\_\_\_\_ MEMBER'S FIRST NAME: \_\_\_\_\_

<b>1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION?</b> <input type="checkbox"/> YES (if yes, complete below) <input type="checkbox"/> NO		
<b>MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):</b>  	<b>DURATION OF THERAPY (SPECIFY DATES):</b>  	<b>RESPONSE/REASON FOR FAILURE/ALLERGY:</b>  
<b>2. LIST DIAGNOSES:</b> <input type="checkbox"/> Moderate to severely active rheumatoid arthritis (RA) <input type="checkbox"/> Polyarticular juvenile idiopathic arthritis (pJIA) <input type="checkbox"/> Systemic juvenile Idiopathic arthritis (sJIA) <input type="checkbox"/> Giant Cell Arteritis <input type="checkbox"/> Other Diagnosis _____ ICD-10 Code(s): _____		<b>ICD-10:</b>  
<b>3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.</b>		
<b>For <u>all diagnosis</u>, answer the next 3 question.</b>  Is the drug being prescribed by a rheumatologist? <input type="checkbox"/> Yes <input type="checkbox"/> No  Does the patient have an active infection? <input type="checkbox"/> Yes <input type="checkbox"/> No  Is the patient on concurrent treatment with another TNF inhibitor (i.e., Rituxan, Orencia, Remicade, Humira, Kineret, Enbrel, Simponi, Cimzia, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>For a <u>moderate to severe active rheumatoid arthritis (RA)</u>, also answer the following:</b> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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)? <input type="checkbox"/> Yes <input type="checkbox"/> No  Has the patient tried and had an inadequate response to a three month trial of Enbrel? <input type="checkbox"/> Yes <input type="checkbox"/> No  Has the patient tried and had an inadequate response to a three month trial of Humira? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>For <u>Polyarticular juvenile idiopathic arthritis(pJIA)</u>, also answer the following:</b> Has the patient had an inadequate response to, intolerance to, or contraindicatin to one or more non-biologic DMARDs for at least 3 consecutive months? * <input type="checkbox"/> Yes <input type="checkbox"/> No  Is the patient 2 years of age or older? <input type="checkbox"/> Yes <input type="checkbox"/> No  Has the patient tried and had an inadequate response to a three month trial of Enbrel? <input type="checkbox"/> Yes <input type="checkbox"/> No  Has the patient tried and had an inadequate response to a three month trial of Humira? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>For <u>systemic juvenile idiopathic arthritis(sJIA)</u>, also answer the following:</b>		





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Does the patient have a documented inadequate response or intolerance to at least one oral systemic agent (i.e. NSAID, corticosteroid)?\*  Yes  No

Is the patient 2 years of age or older?  Yes  No

Does the patient have active polyarticular or systemic JIA?  Yes  No

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:** \_\_\_\_\_

**CONFIDENTIALITY NOTICE:** The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

**FAX THIS FORM TO: 800-424-7640**

**MAIL REQUESTS TO:** Magellan Rx Management Prior Authorization Program; c/o Magellan Health, Inc.  
4801 E. Washington Street, Phoenix, AZ 85034  
Phone: 877-228-7909

