Pharmacy Prior Authorization

AETNA BETTER HEALTH ILLINOIS (MEDICAID)

Actemra (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois at **1-855-684-5250**.
When conditions are met, we will authorize the coverage of Actemra (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(please circle)*

Actemra (tocilizumab)

Other, please specify_____

Quantity _____ Frequency _____ Strength _____

Route of Administration _____ Expected Length of therapy _____

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone: _____

Prescribing Physician

Physician Name: _____

Specialty: _____ NPI Number: _____

Physician Fax: _____ Physician Phone: _____

Physician Address: _____ City, State, Zip: _____

Diagnosis:_____ ICD Code:_____

Please circle the appropriate answer for each question.

1. Has this plan authorized Actemra in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

   [If no, skip to question 5.]

2. Is the prescribed dose within the FDA-approved dosing (based on weight)? Y N

   Please document current weight: _____

   [If no, then no further questions.]

3. Has the patient had at least a 20% improvement in symptoms? Y N

[If no, then no further questions.]

4. Have labs been completed to confirm that patient has ALL of the following: A) ANC greater than or equal to 500 per mm3, B) Platelets greater than or equal to 50,000 per mm3, and C) ALT and AST less than or equal to 5 times the ULN (upper limit of normal) Y N

   [No further questions.]

5. Does the patient have a diagnosis of rheumatoid arthritis (RA) with moderate to high disease activity? Y N

   [If no, skip to question 10.]

6. Has the patient had failure to an adequate trial (3 months) of two disease modifying anti-rheumatic drugs (DMARDs) regimens (one must be methotrexate)? Y N

   If yes, list medications tried: _____

   Note: Monotherapy regimen: methotrexate (MTX), hydroxychloroquine (HCQ), leflunomide (LEF), sulfasalazine (SSZ).

   Combination regimen: MTX+SSZ+HCQ; MTX+HCQ, MTX+LEF, MTX+SSZ, SSZ+HCQ

   [If yes, skip to question 8.]

7. Does the patient have a contraindication to methotrexate? Y N

   Note: Contraindications such as Pregnancy, alcoholism, Chronic liver disease, Leukopenia, thrombocytopenia, or anemia.

   If yes, please document contraindication:_____

   [If no, then no further questions]

8. Has the patient had a trial and failure of at least one formulary anti-TNF? Y N

   Please list agent tried:_____

   [If no, then no further questions.]

9. Is the patient at least 18 years of age? Y N

   [If no, then no further questions.]

   [If yes, skip to question 21.]

10. Does the patient have a diagnosis of juvenile idiopathic arthritis (JIA)? Y N

    [If no, then no further questions.]

11. Does the patient have the systemic subtype of JIA? Y N

    [If no, skip to question 15.]

12. Does the patient currently have ACTIVE systemic features AND synovitis in at least one joint? Y N

    Note: Systemic features such as fever, evanescent rash, lymphadenopathy, hepatomegaly, splenomegaly, or serositis.

    If yes, please list:_____

    [If yes, skip to question 19.]

13. Does the patient continue to have synovitis in at least 1 joint despite 3 months of treatment with methotrexate or leflunomide? Y N

    [If yes, skip to question 19.]

14. Does the patient contraindications to methotrexate and leflunomide? Y N

    Note: Contraindications such as Pregnancy, alcoholism, Chronic liver disease, Leukopenia, thrombocytopenia, or anemia.

    If yes, please document contraindication:_____

    [If no, then no further questions.]

    [If yes, skip to question 19.]

15. Does the patient have moderate to severe polyarticular JIA? Y N

    [If no, then no further questions.]

16. Has the patient had failure to an adequate trial (3 months) of methotrexate? Y N

    [If yes, skip to question 18.]

17. Does the patient have a contraindication to methotrexate? Y N

    Note: Contraindications such as Pregnancy, alcoholism, Chronic liver disease, Leukopenia, thrombocytopenia, or anemia.

If yes, please document contraindication:_____

[If no, then no further questions]

18. Has the patient had a trial and failure of at least one formulary anti-TNF? Y N

    Please list agent tried:_____

    [If no, then no further questions.]

19. Is the patient at least 2 years of age? Y N

    [If no, then no further questions.]

20. Is the request for the IV formulation? Y N

    NOTE: SQ use is not FDA-approved for JIA

    [If no, then no further questions.]

21. Is the prescribed dose within the FDA-approved dosing (based on weight)? Y N

    Please document current weight or submit records:
    _____

    NOTE: requests without patient's weight will not be accepted

    [If no, then no further questions.]

22. Is Actemra being prescribed by, or in consultation with a rheumatologist? Y N

    [If no, then no further questions.]

23. Have labs been completed to confirm that patient has ALL of the following: A) ANC greater than or equal to 2,000 per mm3, B) Platelets greater than or equal to 100,000 per mm3, and C) ALT and AST less than or equal to 1.5 times the ULN Y N

    [If no, then no further questions.]

24. Has the patient been screened for latent tuberculosis (TB) and hepatitis B? Y N

    [If no, then no further questions.]

25. Does the patient have an active infection (including Hepatitis B Y N

and/or tuberculosis (TB)?

[If no, skip to question 27.]

26. Is the patient currently receiving or has completed treatment for latent TB infection or Hepatitis B? Y N

[If no, then no further questions.]

27. Will Actemra be given in combination with another biologic DMARD? Y N

Comments:

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

Prescriber (Or Authorized) Signature Date