Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Actemra (tocilizumab) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 6 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Actemra (tocilizumab).** Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: 1-866-331-2104]. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless this form is complete. The KP-MAS Formulary can be found at: http://pithelp.appl.kp.org/MAS/formulary.html**

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Prescriber Information

Is the prescriber a rheumatologist? □ No □ Yes

If consulted with a specialist, specialist name and specialty: _____

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

Please check the boxes that apply:
□ Initial Request □ Continuation of Therapy Request

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____

5– Diagnosis/Clinical Criteria

Initial Therapy:

1. Does the member have diagnosis of rheumatoid arthritis? **AND**
   □ No □ Yes
2. Does the member have intolerance, contraindication to, or failed treatment with at least a 6-week trial of one of the following:
   - Subcutaneous methotrexate, hydroxychloroquine, leflunomide, or sulfasalazine, AND
   - Xeljanz (tofacitinib), AND
   - At least 1 TNF inhibitor (e.g., Humira, Enbrel, Inflectra)

   □ No □ Yes

   OR
3. Does the member have diagnosis of giant arteritis?
   □ No □ Yes

   OR
4. Does the member have diagnosis of active polyarticular or systemic juvenile idiopathic arthritis? **AND**
   □ No □ Yes
5. The member must not be receiving Actemra in combination with any of the following:
   - Biologic DMARD (e.g., Enbrel, Humira, Cimzia, Simponi)
   - Janus kinase inhibitor (e.g., Xeljanz, Olumiant)

   □ No □ Yes

Continuation of Therapy:

1. Does the member document a clinically significant benefit from medication? **AND**
   □ No □ Yes
2. Has a specialist follow-up occurred in the last 12 months?
   □ No □ Yes

7 – Prescriber Sign-Off

Additional Information – Please provide any additional information that should be taken into consideration.

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:	**Date:**