BlueCross BlueShield
Federal Employee Program

ACTEMRA
PRIOR APPROVAL REQUEST

Send completed form to:
Blue Shield of California
Fax: 1-855-895-3504

Additional information is required to process your claim for prescription drugs. Please complete the cardholder portion, and have the prescribing physician complete the physician portion and submit this completed form. All incomplete and illegible forms will be returned to the patient.

## CARDHOLDER / PATIENT INFORMATION

Cardholder Name: _____ / _____ / _____
First MI Last

Patient Name: _____ / _____ / _____
First MI Last

Patient Address: _____
Street City State Zip

Patient Date of Birth: ____ / ____ / ____ Sex: M ____ F ____ **R** |_|_|_|_|_|_|_|_|_|

Cardholder Identification Number

## PHYSICIAN COMPLETES

## Actemra (tocilizumab)

NOTE: Form must be completed in its **entirety** for processing

**Enbrel and Humira are preferred/participating products for RA/pJIA. Please consider prescribing a preferred/participating product. Patients who switch to Enbrel/Humira will be eligible for 2 copays at no cost in the 2016 benefit year.**

1. Has the patient received a Prior Authorization for a different TNF agent previously? ❑Yes ❑No
2. Is Actemra going to be used in combination with any other biologic disease-modifying anti-rheumatic drug (DMARD) or targeted synthetic DMARD? ❑Yes ❑No
(examples of biologic agents: Cimzia, Enbrel, Humira, Kineret, Orencia, Remicade, Rituxan, Simponi, Stelara, and Xeljanz)
3. Does the patient have any active infections (including tuberculosis (TB) or hepatitis B virus (HBV))? ❑Yes ❑No
4. What is the patient's **diagnosis?**

❑ Rheumatoid Arthritis (RA) **(*please answer the following questions*)**
a. Is/was the Rheumatoid Arthritis moderately to severely active prior to initial therapy? ❑Yes ❑No
b. Would you like to switch the patient to a preferred/participating product? ❑Enbrel ❑Humira ❑No

❑ Polyarticular juvenile idiopathic arthritis (pJIA) **(*please answer the following questions*)**
a. Is/was the polyarticular juvenile idiopathic arthritis active prior to initial therapy? ❑Yes ❑No
b. Would you like to switch the patient to a preferred/participating product? ❑Enbrel ❑Humira ❑No

Systemic juvenile idiopathic arthritis (sJIA) **(*please answer the following question*)**
a. Is/was the systemic juvenile idiopathic arthritis active prior to initial therapy? ❑Yes ❑No
Other Diagnosis (*please specify*): _____

5. Has the patient been receiving **Actemra** therapy for at least **6 months** continuously, excluding samples?

❑**YES –** this would be the **CONTINUATION of therapy**, please answer **the following** question:
a. Has the patient's condition improved or stabilized since starting Actemra therapy? ❑Yes ❑No

❑**NO** – this would be the **INITIATION** of Actemra therapy, please answer **the following** questions:
Has the patient had a recent test for a latent tuberculosis (TB) infection? ❑Yes* ❑ No
***If YES,*** what was the result of the TB test? ❑ Negative ❑ Positive*
***If POSITIVE***, is the patient receiving treatment or has the patient already completed treatment for TB? ❑Yes ❑ No
Does the patient have any active bacterial, invasive fungal, viral or opportunistic infections present? ❑ Yes ❑ No c. Is the patient at risk for hepatitis B virus (HBV)? ❑Yes* ❑ No
***If YES,*** has HBV been ruled out or has therapy been started for treatment of the HBV infection? ❑Yes ❑No

Rheumatoid Arthritis (RA) (please answer the following question)
d. Has the patient experienced an inadequate response, intolerance, or contraindication to one or more DMARDs? ❑Yes ❑No



**REQUESTS FOR ACTEMRA FOR RA AND pJIA REQUIRE PAGE 2 TO BE COMPLETED FOR PROCESSING**

BlueCross BlueShield
Federal Employee Program

# ACTEMRA
# PRIOR APPROVAL REQUEST

Send completed form to:
Blue Shield of California
Fax: 1-855-895-3504

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer.

_____ ( _____ ) _____ ( _____ ) _____
Physician Name (Print Clearly) Phone Fax

_____ _____ _____ _____
Street Address City State Zip

_____ _____ _____ / _____ / _____
Prescriber's NPI Physician Signature Date

**1. Has the patient received at least 30 days of Actemra within the past 4 months? ❑ Yes ❑ No**

**2. If the patient has previously been treated with Actemra, have they had a break for more than 4 months due to a medical reason such as pregnancy, surgery, or intercurrent medical illness?**

***If YES*, please specify medical reason:**

_____
_____ _____

**3. Does the patient have a contraindication to Enbrel and Humira? ❑ Yes* ❑ No**

***If YES*, please provide specific details regarding contraindication below:**

_____
_____

**4. Does the patient have a history of demyelinating disorder? ❑ Yes ❑ No 5. Does the patient have a history of congestive heart failure? ❑ Yes ❑ No 6. Does the patient have a history of Hepatitis B Virus infection? ❑ Yes ❑ No 7. Does the patient have autoantibody formation / lupus-like syndrome? ❑ Yes ❑ No 8. Has the patient had an inadequate response, intolerance, or confirmed adverse event to both Enbrel and Humira? ❑ Yes* ❑ No**

***If YES*, please describe the inadequate response, intolerance, or adverse event below:**

_____
_____

**9. Has the patient tried either Enbrel or Humira? ❑ Yes ❑ No**

**10. Is there a clinical reason for not trying both Enbrel and Humira? ❑ Yes* ❑ No *If YES*, please describe the clinical reason below:**

_____
_____



**REQUESTS FOR ACTEMRA FOR RA AND pJIA REQUIRE PAGE 2 TO BE COMPLETED FOR PROCESSING**