US Family Health Plan
Prior Authorization Request Form for
tocilizumab subcutaneous **(Actemra SC)**

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be **faxed** to **855-273-5735**

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007** **usfamilyhealth.org/rx-pa**

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID: _____ Phone: _____
Date of Birth: Secure Fax:

Step 2 **Please complete clinical assessment:**

1. Humira is the Department of Defense's preferred targeted immune biologic. Has the patient tried Humira?	☐ Yes Proceed to question **3**	☐ No Proceed to question **2**
2. Is the patient an adult (18 years of age or older) with a diagnosis of giant cell arteritis?	☐ Yes Proceed to question **13**	☐ No Proceed to question **5**
3. Has the patient had an inadequate response to Humira?	☐ Yes Proceed to question **6**	☐ No Proceed to question **4**
4. Has the patient experienced an adverse reaction to Humira that is not expected to occur with the requested agent?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
5. Does the patient have a contraindication to Humira (adalimumab)?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Is the patient 18 years of age or older?	☐ Yes Proceed to question **7**	☐ No Proceed to question **8**
7. What is the indication or diagnosis?	☐ moderate to severely active **rheumatoid arthritis** - proceed to question **10** ☐ other indication or diagnosis **STOP: Coverage not approved.**	

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8. Is the patient 2 years of age or older?		☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. What is the indication or diagnosis?	☐ active **polyarticular Juvenile Idiopathic Arthritis (pJIA)** - proceed to question **12** ☐ active **systemic Juvenile Idiopathic Arthritis (sJIA)** - proceed to question **12** ☐ other indication or diagnosis - **STOP: coverage not approved.**		
10. Has the patient had an inadequate response to at least 1 disease modifying anti-rheumatic drug (DMARD)?		☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. Does the patient have platelets less than 100,000/mm^3 or liver transaminases above 1.5 time UNL?		☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **12**
12. Does the patient have evidence of a negative TB test result in the past 12 months (or TB is adequately managed)?		☐ Yes Proceed to question **13**	☐ No **STOP** **Coverage not approved**
13. Will the patient be receiving other targeted immunomodulatory biologics with Actemra, including but not limited to the following: Cimzia, Cosentyx, Enbrel, Humira, Ilumya, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Rituxan, Siliq, Simponi, Stelara, Taltz, Tremfya or Xeljanz/Xeljanz XR?		☐ Yes **STOP** **Coverge not approved**	☐ No **Sign and date below**
Note: Subcutaneous Actemra is not approved for use in cytokine release syndrome			

Step 3

I certify the above is true to the best of my knowledge. Please sign and date

Prescriber Signature _____ Date _____

[24 April 2019]