US Family Health Plan

Prior Authorization Request Form for

Tocilizumab Subcutaneous (Actemra SC, Actemra Actpen)

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**

Clinical documentation may be required for approval

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 **4**	☐ No proceed to question **2**
2. How old is the patient?	☐ 18 years of age or older proceed to question **3**	☐ Less than 18 years of age proceed to question **8**
3. Does the patient have one of the following indications or diagnosis?	☐ Giant cell arteritis - proceed to question **12** ☐ slowing the rate of decline in pulmonary function in systemic sclerosis-associated lung disease (SSc-ILD) - proceed to question **12** ☐ Other - proceed to question **6**	
4. Has the patient had an inadequate response to Humira?	☐ Yes proceed to question **7**	☐ No proceed to question **5**
5. Has the patient experienced an adverse reaction to Humira that is not expected to occur with the requested agent	☐ Yes proceed to question **7**	☐ No **STOP** **Coverage not approved**
6. Does the patient have a contraindication to Humira (adalimumab)?	☐ Yes proceed to question **7**	☐ No **STOP** **Coverage not approved**

7. What is the indication or diagnosis?	☐ moderate to severely active rheumatoid arthritis – proceed to question **11** ☐ Giant cell arteritis – proceed to question **12** ☐ Systemic sclerosis-associated lung disease (SSc-ILD) – proceed to question **12** ☐ Other indication or diagnosis **– STOP: Coverage not approved.**		
8. Is the patient 2 years of age or older?		☐ Yes proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Does the patient have a contraindication to Humira (adalimumab)?		☐ Yes proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. What is the indication or diagnosis?	☐ active polyarticular Juvenile Idiopathic Arthritis (pJIA) – proceed to question **13** ☐ systemic Juvenile Idiopathic Arthritis (sJIA) – proceed to question **13** ☐ Other indication or diagnosis – **STOP: coverage not approved.**		
11. Has the patient had an inadequate response to at least 1 or more disease modifying anti-rheumatic drugs (DMARDS) non-biologic systemic therapy. (For example: methotrexate, aminosalicylates [for example, sulfasalazine, mesalamine], corticosteroids, immunosuppressants [for example, azathioprine])?		☐ Yes proceed to question **12**	☐ No **STOP** **Coverage not approved**
12. 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 **13**
13. 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 **14**	☐ No **STOP** **Coverage not approved**
14. Will the patient be receiving other targeted immunomodulatory biologics with Actemra, including but not limited to the following: certolizumab (Cimzia), etanercept (Enbrel), golimumab (Simponi), infliximab (Remicade), apremilast (Otezla), ustekinumab (Stelara), abatacept (Orencia), anakinra (Kineret), tocilizumab (Actemra), tofacitinib (Xeljanz/Xeljanz XR), rituximab (Rituxan), secukinumab (Cosentyx), ixekizumab (Taltz), brodalumab (Siliq), sarilumab (Kevzara), guselkumab (Tremfya), baricitinib (Olumiant), tildrakizumab (Ilumya), risankizumab (Skyrizi), or upadacitinib (Rinvoq ER)?		☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

Step 3

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

Prescriber Signature _____ Date _____