

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**

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

Patient Name: _____ Address: _____ Sponsor ID #: _____ Date of Birth: _____	Physician Name: _____ Address: _____ Phone #: _____ Secure Fax #: _____
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Step 2 Please complete clinical assessment:

1. Humira is the Department of Defense's preferred targeted immune biologic. Has the patient tried Humira?	<input type="checkbox"/> Yes proceed to question 4	<input type="checkbox"/> No proceed to question 2
2. How old is the patient?	<input type="checkbox"/> 18 years of age or older proceed to question 3	<input type="checkbox"/> Less than 18 years of age proceed to question 8
3. Does the patient have one of the following indications or diagnosis?	<input type="checkbox"/> Giant cell arteritis - proceed to question 12 <input type="checkbox"/> slowing the rate of decline in pulmonary function in systemic sclerosis-associated lung disease (SSc-ILD) - proceed to question 12 <input type="checkbox"/> Other - proceed to question 6	
4. Has the patient had an inadequate response to Humira?	<input type="checkbox"/> Yes proceed to question 7	<input type="checkbox"/> 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	<input type="checkbox"/> Yes proceed to question 7	<input type="checkbox"/> No STOP Coverage not approved
6. Does the patient have a contraindication to Humira (adalimumab)?	<input type="checkbox"/> Yes proceed to question 7	<input type="checkbox"/> No STOP Coverage not approved

Continue on next page

7. What is the indication or diagnosis?	<input type="checkbox"/> moderate to severely active rheumatoid arthritis – proceed to question 11 <input type="checkbox"/> Giant cell arteritis – proceed to question 12 <input type="checkbox"/> Systemic sclerosis-associated lung disease (SSc-ILD) – proceed to question 12 <input type="checkbox"/> Other indication or diagnosis – STOP: Coverage not approved.	
8. Is the patient 2 years of age or older?	<input type="checkbox"/> Yes proceed to question 9	<input type="checkbox"/> No STOP Coverage not approved
9. Does the patient have a contraindication to Humira (adalimumab)?	<input type="checkbox"/> Yes proceed to question 10	<input type="checkbox"/> No STOP Coverage not approved
10. What is the indication or diagnosis?	<input type="checkbox"/> active polyarticular Juvenile Idiopathic Arthritis (pJIA) – proceed to question 13 <input type="checkbox"/> systemic Juvenile Idiopathic Arthritis (sJIA) – proceed to question 13 <input type="checkbox"/> 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])?	<input type="checkbox"/> Yes proceed to question 12	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> 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)?	<input type="checkbox"/> Yes proceed to question 14	<input type="checkbox"/> 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)?	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Sign and date below

Step 3 I certify the above is true to the best of my knowledge. Please sign and date:

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_____ Prescriber Signature

_____ Date