Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Actemra (tocilizumab) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorization: 12 month

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:** Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Patient Information

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

2 – Provider Information

Provider Name: _____ Specialty: _____ Provider NPI: _____

Provider Address: _____

Provider Phone #: _____Provider 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

1. Does the member have diagnosis of one of the following? **AND**
   □ Rheumatoid Arthritis (RA)

   □ Systemic Juvenile Idiopathic Arthritis (SJIA)- 2 years of age and older

   □ Polyarticular juvenile idiopathic arthritis (pJIA) -2 years of age and older

   □ Giant Cell Arteritis (GCA)

   □ Systemic Sclerosis-Associated Interstitial Lung Disease (SSc-ILD)

   □ Other: _____

2. If this is being used for Rheumatoid Arthritis (RA), Polyarticular Juvenile Idiopathic Arthritis (PJIA) or Systemic Juvenile Idiopathic Arthritis (SJIA):
   a. Did the patient try and fail methotrexate? **OR**
      □ No □ Yes

   b. Will this medication be used in conjunction with Methotrexate? **OR**
      □ No □ Yes

   c. Does the patient have a contraindication to Methotrexate? (e.g., alcohol abuse, cirrhosis, chronic liver disease, or other contraindication) **AND**
      □ No □ Yes

   d. Did the patient try and fail another DMARD (other than Methotrexate), such as azathioprine, d-penicillamine, cyclophosphamide, cyclosporine, gold salts, hydroxychloroquine, leflunomide, sulfasalazine, or tacrolimus?
      □ No □ Yes

6 – Provider Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____

_____

_____

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

Provider Signature:	**Date:**