PRIORITY PARTNERS
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

Actemra Tofidence

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form along with supporting clinical documentation to Priority Partners, toll-free at 1-866-212-4756 to initiate the review process.** If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4**.**

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

Drug Information:

Strength/Measure _____*Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un

Directions(sig) _____*Route of administration* _____

Dosing frequency _____

What is the ICD-10 code? _____

Site of Service Questions:

A. Indicate the site of service requested:
❑ *Ambulatory Surgical (POS Code 24)*
❑ *Off-Campus Outpatient Hospital (POS Code 19)*
❑ *Office (POS Code 11)*
❑ *Home (POS Code 12)*
❑ *Off Campus Outpatient Hospital (POS Code 22)*

B. Is the patient less than 18 years of age?
❑ Yes, *skip to Clinical Criteria Questions*
❑ No

C. Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (eg acetaminophen, steroids, diphenhydramine, fluids, other pre- medications or slowing of infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or

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 JHHC PP SOC Actemra SGM 1959-A – 02/2024.

seizures) during or immediately after an infusion? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.*** ❑ Yes, *skip to Clinical Criteria Questions* ❑ No

D. Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?
ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

E. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

F. Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

G. Has the patient's home been deemed not eligible or appropriate for home infusion services by a home infusion provider? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

H. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting?
ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation. ❑ Yes ❑ No

Clinical Criteria Questions:

What product is being requested? ❑ Actemra ❑ Tofidence

1. Will the requested drug be used in combination with any other biologic (e.g., Humira) or targeted synthetic drug (e.g., Olumiant, Otezla, Xeljanz) for the same indication?
❒ Yes, *Continue to 2*
❒ No, *Continue to 2*

2. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic drug (e.g., Olumiant, Xeljanz) associated with an increased risk of tuberculosis (TB)?
❒ Yes, *Continue to 6*
❒ No, *Continue to 3*

3. Has the patient had a tuberculosis (TB) test (e.g., tuberculosis skin test [PPD], interferon-release assay [IGRA], chest x-ray) within 6 months of initiating therapy?
❒ Yes, *Continue to 4*
❒ No, *Continue to 4*

4. What were the results of the tuberculosis (TB) test?

❒ Positive for TB, *Continue to 5*

❒ Negative for TB, *Continue to 6*

❒ Unknown, *Continue to 5*

5. Which of the following applies to the patient?

❒ Patient has latent TB and treatment for latent TB has been initiated, *Continue to 6*

❒ Patient has latent TB and treatment for latent TB has been completed, *Continue to 6*

❒ Patient has latent TB and treatment for latent TB has not been initiated, *Continue to 6*

❒ Patient has active TB, *Continue to 6*

6. What is the diagnosis?

❒ Rheumatoid arthritis, *Continue to 7*

❒ Polyarticular juvenile idiopathic arthritis (pJIA), *Continue to 22*

❒ Oligoarticular juvenile idiopathic arthritis, *Continue to 22*

❒ Systemic juvenile idiopathic arthritis (sJIA), *Continue to 35*

❒ Giant cell arteritis, *Continue to 69*

❒ Systemic sclerosis-associated interstitial lung disease (SSc-ILD), *Continue to 84*

❒ Unicentric Castleman disease, *Continue to 45*

❒ Multicentric Castleman disease, *Continue to 55*

❒ Immune checkpoint inhibitor-related inflammatory arthritis, *Continue to 61*

❒ Cytokine release syndrome, *Continue to 77*

❒ Acute graft versus host disease, *Continue to 81*

❒ Other, please specify. _____, *No further questions*

7. Has the patient been diagnosed with moderately to severely active rheumatoid arthritis (RA)?

❒ Yes, *Continue to 8*

❒ No, *Continue to 8*

8. Is the patient an adult (18 years of age or older)?

❒ Yes, *Continue to 9*

❒ No, *Continue to 9*

9. Is the requested drug being prescribed by or in consultation with a rheumatologist?

❒ Yes, *Continue to 10*

❒ No, *Continue to 10*

10. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?

❒ Yes, *Continue to 11*

❒ No, *Continue to 15*

11. Is the patient currently receiving the requested drug or a biosimilar of the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 15*

❒ No, *Continue to 12*

❒ Unknown, *Continue to 15*

12. Has the patient achieved or maintained a positive clinical response since starting treatment with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 13*
❒ No, *Continue to 14*

13. Has the patient experienced substantial disease activity improvement (e.g., at least 20% from baseline) in tender joint count, swollen joint count, pain, or disability? ***ACTION REQUIRED***: If Yes, please attach chart notes or medical record documentation supporting positive clinical response and substantial disease activity improvement.
❒ Yes, *Continue to 89*
❒ No, *Continue to 14*

14. Is this a request for an increase in dosing regimen due to the patient not achieving an adequate clinical response at the current dose or frequency?
❒ Yes, *Continue to 89*
❒ No, *Continue to 89*

15. Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Rinvoq, Xeljanz) indicated for the treatment of moderately to severely active rheumatoid arthritis (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried.
❒ Yes, *Continue to 89*
❒ No, *Continue to 16*

16. Does the patient meet either of the following: a) the patient was tested for the rheumatoid factor (RF) biomarker and the RF biomarker test was positive, or b) the patient was tested for the anti-cyclic citrullinated peptide (anti-CCP) biomarker and the anti-CCP biomarker test was positive? ***ACTION REQUIRED***: If Yes, please attach laboratory results, chart notes, or medical record documentation of biomarker testing.
❒ Yes, *Continue to 18*
❒ No, *Continue to 17*

17. Has the patient been tested for all of the following biomarkers: a) rheumatoid factor (RF), b) anti-cyclic citrullinated peptide (anti-CCP), and c) C-reactive protein (CRP) and/or erythrocyte sedimentation rate (ESR)? ***ACTION REQUIRED***: If Yes, please attach laboratory results, chart notes, or medical record documentation of biomarker testing.
❒ Yes, *Continue to 18*
❒ No, *Continue to 18*

18. Has the patient experienced an inadequate response after at least 3 months of treatment with methotrexate at a dose greater than or equal to 15 mg per week? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.
❒ Yes, *Continue to 89*
❒ No, *Continue to 19*

19. Has the patient experienced an intolerance to methotrexate? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.

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❒ Yes, *Continue to 89*
❒ No, *Continue to 20*

20. Does the patient have a contraindication to methotrexate? ***ACTION REQUIRED***: If Yes, please attach documentation of clinical reason to avoid therapy.
❒ Yes, *Continue to 21*
❒ No, *Continue to 21*

21. Please indicate the contraindication to methotrexate.

❒ Clinical diagnosis of alcohol use disorder, alcoholic liver disease, or other chronic liver disease, *Continue to 89*

❒ Drug interaction, *Continue to 89*

❒ Risk of treatment-related toxicity, *Continue to 89*

❒ Pregnancy or currently planning pregnancy, *Continue to 89*

❒ Breastfeeding, *Continue to 89*
❒ Significant comorbidity prohibits use of systemic agents (e.g., liver or kidney disease, blood dyscrasias, uncontrolled hypertension), *Continue to 89*

❒ Hypersensitivity, *Continue to 89*

❒ History of intolerance or adverse event, *Continue to 89*

❒ Other, please specify. _____, *Continue to 89*

22. Has the patient been diagnosed with active articular juvenile idiopathic arthritis?
❒ Yes, *Continue to 23*
❒ No, *Continue to 23*

23. Is the patient 2 years of age or older?
❒ Yes, *Continue to 24*
❒ No, *Continue to 24*

24. Is the requested drug being prescribed by or in consultation with a rheumatologist?
❒ Yes, *Continue to 25*
❒ No, *Continue to 25*

25. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 26*
❒ No, *Continue to 29*

26. Is the patient currently receiving the requested drug or a biosimilar of the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 29*

❒ No, *Continue to 27*

❒ Unknown, *Continue to 29*

27. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug or a biosimilar of the requested drug?

❒ Yes, *Continue to 28*
❒ No, *Continue to 28*

28. Which of the following has the patient experienced an improvement in from baseline? ***ACTION REQUIRED***: Please attach chart notes or medical record documentation supporting positive clinical response.
❒ Number of joints with active arthritis (e.g., swelling, pain, limitation of motion) ***ACTION REQUIRED****: Submit supporting documentation, Continue to 89*
❒ Number of joints with limitation of movement ***ACTION REQUIRED****: Submit supporting documentation, Continue to 89*

❒ Functional ability ***ACTION REQUIRED****: Submit supporting documentation, Continue to 89*

❒ None of the above, *Continue to 89*
29. Has the patient ever received or is currently receiving a biologic (e.g., Humira) or targeted synthetic drug (e.g., Xeljanz) indicated for the treatment of active articular juvenile idiopathic arthritis (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried.
❒ Yes, *Continue to 89*
❒ No, *Continue to 30*

30. Has the patient had an inadequate response to methotrexate or another conventional synthetic drug (e.g., leflunomide, sulfasalazine, hydroxychloroquine) administered at an adequate dose and duration? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.
❒ Yes, *Continue to 89*
❒ No, *Continue to 31*

31. Has the patient had an inadequate response to a trial of scheduled non-steroidal anti-inflammatory drugs (NSAIDs) and/or intra-articular glucocorticoids (e.g., triamcinolone hexacetonide)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.
❒ Yes, *Continue to 32*
❒ No, *Continue to 33*

32. Does the patient have one of the following risk factors for poor outcome: a) involvement of ankle, wrist, hip, sacroiliac joint, and/or temporomandibular joint (TMJ), b) presence of erosive disease or enthesitis, c) delay in diagnosis, d) elevated levels of inflammation markers, or e) symmetric disease?
❒ Yes, *Continue to 89*
❒ No, *Continue to 33*

33. Does the patient have any of the following risk factors for disease severity and potentially a more refractory disease course: a) positive rheumatoid factor, b) positive anti-cyclic citrullinated peptide antibodies, or c) pre-existing joint damage?
❒ Yes, *Continue to 34*
❒ No, *Continue to 34*

34. Does the patient meet any of the following: a) high-risk joints are involved (e.g., cervical spine, wrist, or hip), b) high disease activity, or c) high risk for disabling joint disease?

❒ Yes, *Continue to 89*
❒ No, *Continue to 89*

35. Is the patient 2 years of age or older?
❒ Yes, *Continue to 36*
❒ No, *Continue to 36*

36. Is the requested drug being prescribed by or in consultation with a rheumatologist?
❒ Yes, *Continue to 37*
❒ No, *Continue to 37*

37. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 38*
❒ No, *Continue to 41*

38. Is the patient currently receiving the requested drug or a biosimilar of the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 41*

❒ No, *Continue to 39*

❒ Unknown, *Continue to 41*

39. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 40*
❒ No, *Continue to 40*

40. Which of the following has the patient experienced an improvement in from baseline? ***ACTION REQUIRED***: Please attach chart notes or medical record documentation supporting positive clinical response.
❒ Number of joints with active arthritis (e.g., swelling, pain, limitation of motion) ***ACTION REQUIRED****: Submit supporting documentation, Continue to 89*
❒ Number of joints with limitation of movement ***ACTION REQUIRED****: Submit supporting documentation, Continue to 89*

❒ Functional ability ***ACTION REQUIRED****: Submit supporting documentation, Continue to 89*
❒ Systemic features (e.g., fevers, evanescent rash, lymphadenopathy, hepatomegaly, splenomegaly, or serositis) ***ACTION REQUIRED****: Submit supporting documentation, Continue to 89*

❒ None of the above, *Continue to 89*

41. Has the patient been diagnosed with active systemic juvenile idiopathic arthritis (sJIA)?
❒ Yes, *Continue to 42*
❒ No, *Continue to 42*

42. Has the patient ever received or is currently receiving a biologic (e.g., Humira) indicated for the treatment of active systemic juvenile idiopathic arthritis (excluding receiving the drug via samples or a manufacturer's patient assistance program)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried.

❒ Yes, *Continue to 89*
❒ No, *Continue to 43*

43. Does the patient have active systemic features (e.g., fever, evanescent rash, lymphadenopathy, hepatomegaly, splenomegaly, serositis)?
❒ Yes, *Continue to 44*
❒ No, *Continue to 44*

44. Has the patient had an inadequate response to non-steroidal anti-inflammatory drugs (NSAIDs) or systemic glucocorticoids? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.
❒ Yes, *Continue to 89*
❒ No, *Continue to 89*

45. Is the requested drug being prescribed by or in consultation with an oncologist or hematologist?
❒ Yes, *Continue to 46*
❒ No, *Continue to 46*

46. Is this a request for continuation of therapy with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 47*
❒ No, *Continue to 49*

47. Is the patient currently receiving the requested drug or a biosimilar of the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 49*

❒ No, *Continue to 48*

❒ Unknown, *Continue to 49*

48. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?
❒ Yes, *Continue to 89*
❒ No, *Continue to 89*

49. Has the patient been tested for human immunodeficiency virus (HIV)?
❒ Yes, *Continue to 50*
❒ No, *Continue to 50*

50. What were the results of the HIV test?

❒ Positive, *Continue to 51*

❒ Negative, *Continue to 51*

❒ Unknown, *Continue to 51*

51. Has the patient been tested for herpesvirus-8?
❒ Yes, *Continue to 52*
❒ No, *Continue to 52*

52. What were the results of the herpesvirus-8 test?

❒ Positive, *Continue to 53*

❒ Negative, *Continue to 53*

❒ Unknown, *Continue to 53*

53. Has the disease progressed following treatment of relapsed or refractory disease?
❒ Yes, *Continue to 54*
❒ No, *Continue to 54*

54. Will the requested drug be used as a single agent?
❒ Yes, *Continue to 89*
❒ No, *Continue to 89*

55. Is the requested drug being prescribed by or in consultation with an oncologist or hematologist?
❒ Yes, *Continue to 56*
❒ No, *Continue to 56*

56. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 57*
❒ No, *Continue to 59*

57. Is the patient currently receiving the requested drug or a biosimilar of the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 59*

❒ No, *Continue to 58*

❒ Unknown, *Continue to 59*

58. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?
❒ Yes, *Continue to 89*
❒ No, *Continue to 89*

59. Has the disease progressed following treatment of relapsed/refractory or progressive disease?
❒ Yes, *Continue to 60*
❒ No, *Continue to 60*

60. Will the requested drug be used as a single agent?
❒ Yes, *Continue to 89*
❒ No, *Continue to 89*

61. Is the requested drug being prescribed by or in consultation with an oncologist, hematologist, or rheumatologist?
❒ Yes, *Continue to 62*
❒ No, *Continue to 62*

62. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?

❒ Yes, *Continue to 63*
❒ No, *Continue to 65*

63. Is the patient currently receiving the requested drug or a biosimilar of the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 65*

❒ No, *Continue to 64*

❒ Unknown, *Continue to 65*

64. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug or a biosimilar of the requested drug? ***ACTION REQUIRED***: Please attach chart notes or medical record documentation supporting positive clinical response.
❒ Yes, *Continue to 89*
❒ No, *Continue to 89*

65. Does the patient have severe immunotherapy-related inflammatory arthritis?
❒ Yes, *Continue to 66*
❒ No, *Continue to 66*

66. Has the patient experienced an inadequate response to corticosteroids or a conventional synthetic drug (e.g., methotrexate, sulfasalazine, leflunomide, hydroxychloroquine)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy.
❒ Yes, *Continue to 89*
❒ No, *Continue to 67*

67. Does the patient have an intolerance or contraindication to corticosteroids? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is if not advisable, please attach documentation of clinical reason to avoid therapy.
❒ Yes, *Continue to 68*
❒ No, *Continue to 68*

68. Does the patient have an intolerance or contraindication to a conventional synthetic drug (e.g., methotrexate, sulfasalazine, leflunomide, hydroxychloroquine)? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is if not advisable, please attach documentation of clinical reason to avoid therapy.
❒ Yes, *Continue to 89*
❒ No, *Continue to 89*

69. Is the patient an adult (18 years of age or older)?
❒ Yes, *Continue to 70*
❒ No, *Continue to 70*

70. Is the requested drug being prescribed by or in consultation with a rheumatologist?

❒ Yes, *Continue to 71*
❒ No, *Continue to 71*

71. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 72*
❒ No, *Continue to 75*

72. Is the patient currently receiving the requested drug or a biosimilar of the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 75*

❒ No, *Continue to 73*

❒ Unknown, *Continue to 75*

73. Has the patient achieved or maintained a positive clinical response as evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 74*
❒ No, *Continue to 74*

74. Which of the following has the patient experienced an improvement in from baseline? ***ACTION REQUIRED***: Please attach chart notes or medical record documentation supporting positive clinical response.

❒ Headaches ***ACTION REQUIRED****: Submit supporting documentation, Continue to 89*

❒ Scalp tenderness ***ACTION REQUIRED****: Submit supporting documentation, Continue to 89*
❒ Tenderness and/or thickening of superficial temporal arteries ***ACTION REQUIRED****: Submit supporting documentation, Continue to 89*
❒ Constitutional symptoms (e.g., weight loss, fever, fatigue, night sweats) ***ACTION REQUIRED****: Submit supporting documentation, Continue to 89*

❒ Jaw and/or tongue claudication ***ACTION REQUIRED****: Submit supporting documentation, Continue to 89*
❒ Acute visual symptoms (e.g., amaurosis fugax, acute visual loss, diplopia) ***ACTION REQUIRED****: Submit supporting documentation, Continue to 89*
❒ Symptoms of polymyalgia rheumatica (e.g., shoulder and/or hip girdle pain) ***ACTION REQUIRED****: Submit supporting documentation, Continue to 89*

❒ Limb claudication ***ACTION REQUIRED****: Submit supporting documentation, Continue to 89*

❒ None of the above, *Continue to 89*

75. Has the diagnosis been confirmed by temporal artery biopsy or cross-sectional imaging?
❒ Yes, *Continue to 89*
❒ No, *Continue to 76*

76. Has the diagnosis been confirmed by acute-phase reactant elevation (i.e., high erythrocyte sedimentation rate [ESR] and/or high serum C-reactive protein [CRP])?
❒ Yes, *Continue to 89*
❒ No, *Continue to 89*

77. Is the requested drug being prescribed by or in consultation with an oncologist or hematologist?

❒ Yes, *Continue to 78*
❒ No, *Continue to 89*

78. Has the patient been diagnosed with chimeric antigen receptor (CAR) T cell-induced cytokine release syndrome (CRS)?
❒ Yes, *Continue to 79*
❒ No, *Continue to 80*

79. Is the patient 2 years of age or older?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

80. Does the patient have refractory cytokine release syndrome (CRS) related to blinatumomab therapy? ***ACTION REQUIRED***: If Yes, please also attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

81. Is the requested drug being prescribed by or in consultation with an oncologist or hematologist?
❒ Yes, *Continue to 82*
❒ No, *Continue to 82*

82. Has the patient experienced an inadequate response to systemic corticosteroids? ***ACTION REQUIRED***: If Yes, please also attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.
❒ Yes, *Continue to 89*
❒ No, *Continue to 83*

83. Does the patient have an intolerance or contraindication to corticosteroids? ***ACTION REQUIRED***: If Yes, please attach chart notes, medical record documentation, or claims history supporting previous medications tried (if applicable), including response to therapy. If therapy is if not advisable, please attach documentation of clinical reason to avoid therapy.
❒ Yes, *Continue to 89*
❒ No, *Continue to 89*

84. Is the patient an adult (18 years of age or older)?
❒ Yes, *Continue to 85*
❒ No, *Continue to 85*

85. Is the requested drug being prescribed by or in consultation with a rheumatologist or pulmonologist?
❒ Yes, *Continue to 86*
❒ No, *Continue to 86*

86. Is this request for continuation of therapy with the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 87*
❒ No, *Continue to 88*

87. Is the patient currently receiving the requested drug or a biosimilar of the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 88*

❒ No, *Continue to 89*

❒ Unknown, *Continue to 88*

88. Has the diagnosis been confirmed by a high-resolution computed tomography (HRCT) study of the chest?
ACTION REQUIRED: If Yes, please attach the radiology report.
❒ Yes, *Continue to 89*
❒ No, *Continue to 89*

89. What is the diagnosis?

❒ Rheumatoid arthritis, *Continue to 90*

❒ Polyarticular juvenile idiopathic arthritis (pJIA), *Continue to 116*

❒ Oligoarticular juvenile idiopathic arthritis, *Continue to 116*

❒ Systemic juvenile idiopathic arthritis (sJIA), *Continue to 123*

❒ Giant cell arteritis, *Continue to 144*

❒ Systemic sclerosis-associated interstitial lung disease (SSc-ILD), *Continue to 151*

❒ Unicentric Castleman disease, *Continue to 130*

❒ Multicentric Castleman disease, *Continue to 130*

❒ Immune checkpoint inhibitor-related inflammatory arthritis, *Continue to 136*

❒ Acute graft versus host disease, *Continue to 130*

90. Is the patient currently receiving the requested drug or a biosimilar of the requested drug?
❒ Yes, *Continue to 91*
❒ No, *Continue to 107*

91. What is the requested product?

❒ Actemra, *Continue to 92*

❒ Tofidence (IV only), *Continue to 93*

92. What is the route of administration?

❒ Intravenous, *Continue to 93*

❒ Subcutaneous, *Continue to 101*

93. Does the prescribed dose exceed 4 mg per kg?
❒ Yes, *Continue to 96*
❒ No, *Continue to 94*

94. Is the prescribed frequency more frequent than one dose every 4 weeks?
❒ Yes, *Continue to 95*
❒ No, *Continue to 95*

95. What is the requested product?

❒ Actemra, *No further questions*

❒ Tofidence, *No further questions*

96. Does the prescribed dose exceed 8 mg per kg?
❒ Yes, *Continue to 97*
❒ No, *Continue to 97*

97. Please select the situation that applies to the patient.

❒ Patient is continuing therapy on current dose, *Continue to 99*

❒ Prescriber is increasing dose, *Continue to 98*

❒ Prescriber is decreasing dose, *Continue to 99*

98. Does the patient require an increased dose due to lack of clinical response at the current dose?
❒ Yes, *Continue to 99*
❒ No, *Continue to 99*

99. Is the prescribed frequency more frequent than one dose every 4 weeks?
❒ Yes, *Continue to 100*
❒ No, *Continue to 100*

100. What is the requested product?

❒ Actemra, *No further questions*

❒ Tofidence, *No further questions*

101. Does the prescribed dose exceed 162 mg?
❒ Yes, *Continue to 102*
❒ No, *Continue to 102*

102. What is the patient's weight? Indicate in kilograms (kg).

❒ Less than 100 kg _____kg, *Continue to 103*

❒ Greater than or equal to 100 kg _____kg, *Continue to 106*

103. Is the prescribed frequency more frequent than one dose EVERY OTHER WEEK?
❒ Yes, *Continue to 104*
❒ No, *No Further Questions*

104. Please select the situation that applies to the patient.

❒ Patient is continuing therapy at current frequency, *Continue to 106*

❒ Prescriber is increasing dosing frequency, *Continue to 105*

105. Does the patient require an increased dosing frequency due to lack of clinical response at the current dose?

❒ Yes, *Continue to 106*
❒ No, *Continue to 106*

106. Is the prescribed frequency more frequent than one dose EVERY WEEK?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

107. What is the requested product?

❒ Actemra, *Continue to 108*

❒ Tofidence (IV only), *Continue to 109*

108. What is the route of administration?

❒ Intravenous, *Continue to 109*

❒ Subcutaneous, *Continue to 112*

109. Does the prescribed dose exceed 4 mg per kg?
❒ Yes, *No Further Questions*
❒ No, *Continue to 110*

110. Is the prescribed frequency more frequent than one dose every 4 weeks?
❒ Yes, *Continue to 111*
❒ No, *Continue to 111*

111. What is the requested product?

❒ Actemra, *No further questions*

❒ Tofidence, *No further questions*

112. Does the prescribed dose exceed 162 mg?
❒ Yes, *Continue to 113*
❒ No, *Continue to 113*

113. What is the patient's weight? Indicate in kilograms (kg).

❒ Less than 100 kg _____kg, *Continue to 114*

❒ Greater than or equal to 100 kg _____kg, *Continue to 115*

114. Is the prescribed frequency more frequent than one dose EVERY OTHER WEEK?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

115. Is the prescribed frequency more frequent than one dose EVERY WEEK?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

116. What is the requested product?

❒ Actemra, *Continue to 117*

❒ Tofidence (IV only), *Continue to 118*

117. What is the route of administration?

❒ Intravenous, *Continue to 118*

❒ Subcutaneous, *Continue to 121*

118. Does the prescribed dose exceed 10 mg per kg?
❒ Yes, *Continue to 119*
❒ No, *Continue to 119*

119. Is the prescribed frequency more frequent than one dose every 4 weeks?
❒ Yes, *Continue to 120*
❒ No, *Continue to 120*

120. What is the requested product?

❒ Actemra, *No further questions*

❒ Tofidence, *No further questions*

121. Does the prescribed dose exceed 162 mg?
❒ Yes, *Continue to 122*
❒ No, *Continue to 122*

122. Is the prescribed frequency more frequent than one dose every 2 weeks?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

123. What is the requested product?

❒ Actemra, *Continue to 124*

❒ Tofidence (IV only), *Continue to 125*

124. What is the route of administration?

❒ Intravenous, *Continue to 125*

❒ Subcutaneous, *Continue to 128*

125. Does the prescribed dose exceed 12 mg per kg?
❒ Yes, *Continue to 126*
❒ No, *Continue to 126*

126. Is the prescribed frequency more frequent than one dose every 2 weeks?
❒ Yes, *Continue to 127*
❒ No, *Continue to 127*

127. What is the requested product?

❒ Actemra, *No further questions*

❒ Tofidence, *No further questions*

128. Does the prescribed dose exceed 162 mg?
❒ Yes, *Continue to 129*
❒ No, *Continue to 129*

129. Is the prescribed frequency more frequent than one dose every week?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

130. Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?
❒ Yes, *Continue to 131*
❒ No, *Continue to 132*

131. What is the requested product?

❒ Actemra, *Continue to 132*

❒ Tofidence (IV only), *Continue to 133*

132. What is the route of administration?

❒ Intravenous, *Continue to 133*

❒ Subcutaneous, *Continue to 133*

133. Does the prescribed dose exceed 8 mg per kg?
❒ Yes, *Continue to 134*
❒ No, *Continue to 134*

134. Is the prescribed frequency more frequent than one dose every 2 weeks?
❒ Yes, *Continue to 135*
❒ No, *Continue to 135*

135. What is the requested product?

❒ Actemra, *No further questions*

❒ Tofidence, *No further questions*

136. Is the requested quantity supported by dosing guidelines found in the compendia or current literature (e.g., Micromedex DrugDex, NCCN compendia, current treatment guidelines)?
❒ Yes, *Continue to 137*
❒ No, *Continue to 137*

137. What is the requested product?

❒ Actemra, *Continue to 138*

❒ Tofidence (IV only), *Continue to 141*

138. What is the route of administration?

❒ Intravenous, *Continue to 141*

❒ Subcutaneous, *Continue to 139*

139. Does the prescribed dose exceed 162 mg?
❒ Yes, *Continue to 140*
❒ No, *Continue to 140*

140. Is the prescribed frequency more frequent than one dose every week?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

141. Does the prescribed dose exceed 8 mg per kg?
❒ Yes, *Continue to 142*
❒ No, *Continue to 142*

142. Is the prescribed frequency more frequent than one dose every 4 weeks?
❒ Yes, *Continue to 143*
❒ No, *Continue to 143*

143. What is the requested product?

❒ Actemra, *No further questions*

❒ Tofidence, *No further questions*

144. What is the requested product?

❒ Actemra, *Continue to 145*

❒ Tofidence (IV only), *Continue to 148*

145. What is the route of administration?

❒ Intravenous, *Continue to 148*

❒ Subcutaneous, *Continue to 146*

146. Does the prescribed dose exceed 162 mg?
❒ Yes, *Continue to 147*
❒ No, *Continue to 147*

147. Is the prescribed frequency more frequent than one dose every week?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

148. Does the prescribed dose exceed 6 mg per kg?
❒ Yes, *Continue to 149*
❒ No, *Continue to 149*

149. Is the prescribed frequency more frequent than one dose every 4 weeks?
❒ Yes, *Continue to 150*
❒ No, *Continue to 150*

150. What is the requested product?

❒ Actemra, *No further questions*

❒ Tofidence, *No further questions*

151. What is the requested product?

❒ Actemra, *Continue to 152*

❒ Tofidence (IV only), *Continue to 152*

152. What is the route of administration?

❒ Intravenous, *Continue to 153*

❒ Subcutaneous, *Continue to 153*

153. Does the prescribed dose exceed 162 mg?
❒ Yes, *Continue to 154*
❒ No, *Continue to 154*

154. Is the prescribed frequency more frequent than one dose every week?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by Priority Partners.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

Send completed form to: Priority Partners Fax: 1-866-212-4756