Prior Authorization Request Form for
tocilizumab subcutaneous **(Actemra SC)**

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

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.**	

Continue on next page

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** **Coverage 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]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: