Actemra

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*_____

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

Site of Service Questions:

A. Indicate the site of service requested:
- ❑ On Campus Outpatient Hospital (22)
- ❑ Off Campus Outpatient Hospital (19)
- ❑ Home (12), *skip to Criteria Questions*
- ❑ Office (11), *skip to Criteria Questions*
- ❑ Ambulatory Surgical Center (24), *skip to Criteria Questions*

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 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:

1. Has the patient been diagnosed with any of the following?
   - ❑ Moderately to severely active rheumatoid arthritis (RA)
   - ❑ Active polyarticular juvenile idiopathic arthritis (pJIA)
   - ❑ Active oligoarticular juvenile idiopathic arthritis
   - ❑ Active systemic juvenile idiopathic arthritis (sJIA)
   - ❑ Giant cell arteritis
   - ❑ Systemic sclerosis-associated interstitial lung disease (SSc-ILD)
   - ❑ Unicentric Castleman's disease
   - ❑ Multicentric Castleman's disease
   - ❑ Immunotherapy-related inflammatory arthritis
   - ❑ Cytokine release syndrome
   - ❑ Acute graft versus host disease
   - ❑ Other _____

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2. What is the ICD-10 code? _____

3. Will the requested drug be used in combination with any other biologic (e.g., Humira) or targeted synthetic disease-modifying antirheumatic drug (DMARD) (e.g., Olumiant, Otezla, Xeljanz)? ❑ Yes ❑ No

4. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic DMARD (e.g., Olumiant, Xeljanz) associated with an increased risk of tuberculosis (TB)? *If Yes, skip to #6* ❑ Yes ❑ No

5. 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 ❑ No *Skip to #8*

6. Does the patient have risk factors for tuberculosis (TB) (e.g., persons with close contact to people with infectious TB disease; persons who have recently immigrated from areas of the world with high rates of TB [e.g., Africa, Asia, Eastern Europe, Latin America, Russia]; children less than 5 years of age who have a positive TB test; groups with high rates of TB transmission [e.g., homeless persons, injection drug users, persons with HIV infection], or persons who work or reside with people who are at an increased risk for active TB [e.g., hospitals, long-term care facilities, correctional facilities, homeless shelters])? ❑ Yes ❑ No *If No, skip to Section A.*

7. Has the patient been tested for tuberculosis (TB) within the previous 12 months? ❑ Yes ❑ No

8. What were the results of the tuberculosis (TB) test?
   ❑ Positive for TB ❑ Negative for TB, *skip to Section A* ❑ Unknown

9. Does the patient have latent or active tuberculosis (TB)? ❑ Latent ❑ Active ❑ Unknown

10. Has treatment for latent tuberculosis (TB) infection been initiated or completed?
    ❑ Yes - treatment initiated
    ❑ Yes - treatment completed
    ❑ No

Section A: Requests for Unicentric or Multicentric Castleman's Disease

11. Is this request for continuation of therapy with the requested drug? ❑ Yes ❑ No *If No, skip to diagnosis section.*

12. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program? *If Yes or Unknown, skip to diagnosis section.* ❑ Yes ❑ No ❑ Unknown

13. Is there evidence of unacceptable toxicity or disease progression on the current regimen? ❑ Yes ❑ No

14. 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 ❑ No

15. What is the route of administration? ❑ Intravenous ❑ Subcutaneous

16. Does the prescribed dose exceed 8 mg per kg? ❑ Yes ❑ No

17. Is the prescribed frequency more frequent than one dose every 2 weeks? ❑ Yes ❑ No

Complete the following section based on the patient's diagnosis, if applicable.

Section B: Rheumatoid Arthritis

18. Is this request for continuation of therapy with the requested drug? ❑ Yes ❑ No *If No, skip to #40*

19. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program? *If Yes or Unknown, skip to #40.* ❑ Yes ❑ No ❑ Unknown

20. What is the route of administration? ❑ Intravenous ❑ Subcutaneous, *skip to #31*

21. Does the prescribed dose exceed 4 mg per kg? *If Yes, skip to #25* ❑ Yes ❑ No

22. Is the prescribed frequency more frequent than one dose every 4 weeks? ❑ Yes ❑ No

23. Has the patient achieved or maintained positive clinical response since starting treatment with the requested drug?
❑ Yes ❑ No

24. What is the percent of disease activity improvement from baseline in tender joint count, swollen joint count, pain, or disability? ***ACTION REQUIRED: Please attach chart notes or medical record documentation supporting positive clinical response.*** _____% *No further questions*

25. Is the prescribed frequency more frequent than one dose every 4 weeks? ❑ Yes ❑ No

26. Does the prescribed dose exceed 8 mg per kg? ❑ Yes ❑ No

27. Please select the situation that applies to the patient.
❑ Patient is continuing therapy on current dose
❑ Prescriber is increasing dose *Skip to #30*
❑ Prescriber is decreasing dose

28. Has the patient achieved or maintained positive clinical response since starting treatment with the requested drug?
❑ Yes ❑ No

29. What is the percent of disease activity improvement from baseline in tender joint count, swollen joint count, pain, or disability? ***ACTION REQUIRED: Please attach chart notes or medical record documentation supporting positive clinical response.*** _____% *No further questions*

30. Does the patient require an increased dose due to lack of clinical response at the current dose?
❑ Yes ❑ No *No further questions*

31. Does the prescribed dose exceed 162 mg? ❑ Yes ❑ No

32. What is the patient's weight? _____ kg *If greater than or equal to 100 kg, skip to #37*

33. Is the prescribed frequency more frequent than one dose EVERY OTHER WEEK?
❑ Yes ❑ No *If No, skip to #38*

34. Please select the situation that applies to the patient.
❑ Patient is continuing therapy at current frequency *Skip to #37*
❑ Prescriber is increasing dosing frequency

35. Does the patient require an increased dosing frequency due to lack of clinical response? ❑ Yes ❑ No

36. Is the prescribed frequency more frequent than one dose EVERY WEEK? ❑ Yes ❑ No *No further questions*

37. Is the prescribed frequency more frequent than one dose EVERY WEEK? ❑ Yes ❑ No

38. Has the patient achieved or maintained positive clinical response since starting treatment with the requested drug?
❑ Yes ❑ No

39. What is the percent of disease activity improvement from baseline in tender joint count, swollen joint count, pain, or disability? ***ACTION REQUIRED: Please attach chart notes or medical record documentation supporting positive clinical response.*** _____% *No further questions*

40. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic DMARD (e.g., Xeljanz) that is indicated for moderately to severely active rheumatoid arthritis? ***ACTION REQUIRED: If 'Yes', please attach chart notes, medical record documentation, or claims history supporting previous medications tried and skip to #51.*** ❑ Yes ❑ No

41. Does the patient meet BOTH of the following: a) the patient was tested for the rheumatoid factor (RF) biomarker AND b) the RF biomarker test was positive? ***ACTION REQUIRED: If 'Yes', please attach laboratory results, chart notes, or medical record documentation of biomarker testing and skip to #48*** ❑ Yes ❑ No

42. Does the patient meet BOTH of the following: a) the patient was tested for the anti-cyclic citrullinated peptide (anti-CCP) biomarker AND b) the anti-CCP biomarker test was positive? ***ACTION REQUIRED: If 'Yes', please attach laboratory results, chart notes, or medical record documentation of biomarker testing and skip to #48***
❑ Yes ❑ No

43. Has the patient been tested for the rheumatoid factor (RF) biomarker? ***ACTION REQUIRED: If 'Yes', please attach laboratory results, chart notes, or medical record documentation of biomarker testing.*** ❑ Yes ❑ No

44. Has the patient been tested for the anti-cyclic citrullinated peptide (anti-CCP) biomarker? ***ACTION REQUIRED: If 'Yes', please attach laboratory results, chart notes, or medical record documentation of biomarker testing.***
❑ Yes ❑ No

45. Has the patient been tested for the C-reactive protein (CRP) and/or erythrocyte sedimentation rate (ESR) biomarker(s)? ***ACTION REQUIRED: If 'Yes', please attach laboratory results, chart notes, or medical record documentation of biomarker testing.*** ❑ Yes ❑ No

46. Please indicate if the patient tested positive or negative for the C-reactive protein (CRP) biomarker, or if the test was not completed. ❑ Positive for CRP ❑ Negative for CRP ❑ Test for CRP was not completed

47. Please indicate if the patient tested positive or negative for the erythrocyte sedimentation rate (ESR) biomarker, or if the test was not completed. ❑ Positive for ESR ❑ Negative for ESR ❑ Test for ESR was not completed

48. Has the patient experienced an inadequate response after at least 3 months of treatment with methotrexate at a dose greater than or equal to 20 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 and skip to #51*** ❑ Yes ❑ No

49. 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 and skip to #51*** ❑ Yes ❑ No

50. Does the patient have a contraindication to methotrexate? ***ACTION REQUIRED: If 'Yes', please attach documentation of clinical reason to avoid therapy.*** ❑ Yes ❑ No
If Yes, indicate the contraindication: _____

51. What is the route of administration? ❑ Intravenous ❑ Subcutaneous, *skip to #54*

52. Does the prescribed dose exceed 4 mg per kg? ❑ Yes ❑ No

53. Is the prescribed frequency more frequent than one dose every 4 weeks? ❑ Yes ❑ No *No further questions*

54. Does the prescribed dose exceed 162 mg? ❑ Yes ❑ No

55. What is the patient's weight? _____ kg *If greater than or equal to 100 kg, skip to #57*

56. Is the prescribed frequency more frequent than one dose every other week? ❑ Yes ❑ No *No further questions*

57. Is the prescribed frequency more frequent than one dose every week? ❑ Yes ❑ No

<u>Section C: Polyarticular and Oligoarticular Juvenile Idiopathic Arthritis</u>

58. Is this request for continuation of therapy with the requested drug? ❑ Yes ❑ No *If No, skip to #62*

59. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program? *If Yes or Unknown, skip to #62.* ❑ Yes ❑ No ❑ Unknown

60. Has the patient achieved or maintained 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?
❑ Yes ❑ No

61. 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), *skip to #66*
    - ❑ Number of joints with limitation of movement, *skip to #66*
    - ❑ Functional ability, *skip to #66*
    - ❑ None of the above

62. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) or targeted synthetic disease-modifying antirheumatic drug (DMARD) indicated for active articular juvenile idiopathic arthritis? ***ACTION REQUIRED: If 'Yes', please attach chart notes, medical record documentation, or claims history supporting previous medications tried and skip to #66.*** ❑ Yes ❑ No

63. Has the patient had an inadequate response to methotrexate or another non-biologic DMARD 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 and skip to #66.*** ❑ Yes ❑ No

64. Does the patient have any of the following risk factors?
    - ❑ Positive rheumatoid factor
    - ❑ Positive anti-cyclic citrullinated peptide antibodies
    - ❑ Pre-existing joint damage
    - ❑ None of the above

65. Does the patient meet any of the following?
    - ❑ High-risk joints are involved (e.g., cervical spine, wrist, or hip)
    - ❑ High disease activity
    - ❑ High risk for disabling joint disease
    - ❑ None of the above

66. What is the route of administration? ❑ Intravenous ❑ Subcutaneous, *skip to #71*

67. Is the prescribed frequency more frequent than one dose every 4 weeks? ❑ Yes ❑ No

68. What is the patient's weight? _____ kg, *If greater than or equal to 30 kg, skip to #70*

69. Does the prescribed dose exceed 10 mg per kg? ❑ Yes ❑ No *No further questions*

70. Does the prescribed dose exceed 8 mg per kg? ❑ Yes ❑ No *No further questions*

71. Does the prescribed dose exceed 162 mg? ❑ Yes ❑ No

72. What is the patient's weight? _____ kg *If greater than or equal to 30 kg, skip to #74*

73. Is the prescribed frequency more frequent than one dose every 3 weeks? ❑ Yes ❑ No *No further questions*

74. Is the prescribed frequency more frequent than one dose every 2 weeks? ❑ Yes ❑ No

Section D: Systemic Juvenile Idiopathic Arthritis (sJIA)

75. Is this request for continuation of therapy with the requested drug? ❑ Yes ❑ No *If No, skip to #79*

76. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program? *If Yes or Unknown, skip to #79* ❑ Yes ❑ No ❑ Unknown

77. Has the patient achieved or maintained positive clinical response evidenced by low disease activity or improvement in signs and symptoms of the condition since starting treatment with the requested drug? ❑ Yes ❑ No

78. 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), *skip to #81*
    - ❑ Number of joints with limitation of movement, *skip to #81*
    - ❑ Functional ability, *skip to #81*
    - ❑ Systemic symptoms (e.g., fevers, evanescent skin rashes), *skip to #81*
    - ❑ None of the above

79. Has the patient ever received (including current utilizers) a biologic (e.g., Humira) indicated for active systemic juvenile idiopathic arthritis? ***ACTION REQUIRED: If 'Yes', please attach chart notes, medical record documentation, or claims history supporting previous medications tried and skip to #81*** ❑ Yes ❑ No

80. Has the patient experienced an inadequate response to ANY of the following? *If Yes, please indicate.* ***ACTION REQUIRED: If 'Yes', please also attach chart notes, medical record documentation, or claims history supporting previous medications tried, including response to therapy.***
    ❑ Yes - At least 1 month trial of NSAIDs
    ❑ Yes - At least 2 weeks of treatment with corticosteroids
    ❑ Yes - At least 3 months of treatment with methotrexate
    ❑ Yes - At least 3 months of treatment with leflunomide
    ❑ No - No history of an inadequate response to any of the above

81. What is the route of administration? ❑ Intravenous ❑ Subcutaneous, *skip to #86*

82. Is the prescribed frequency more frequent than one dose every 2 weeks? ❑ Yes ❑ No

83. What is the patient's weight? _____ kg, *If greater than or equal to 30 kg, skip to #85*

84. Does the prescribed dose exceed 12 mg per kg? ❑ Yes ❑ No *No further questions*

85. Does the prescribed dose exceed 8 mg per kg? ❑ Yes ❑ No *No further questions*

86. Does the prescribed dose exceed 162 mg? ❑ Yes ❑ No

87. What is the patient's weight? _____ kg *If greater than or equal to 30 kg, skip to #89*

88. Is the prescribed frequency more frequent than one dose every 2 weeks?
    ❑ Yes ❑ No *No further questions*

89. Is the prescribed frequency more frequent than one dose every week? ❑ Yes ❑ No

Section E: Unicentric Castleman's Disease

90. Has the patient been tested for human immunodeficiency virus (HIV) ❑ Yes ❑ No

91. What were the results of the HIV test? ❑ Positive ❑ Negative ❑ Unknown

92. Has the patient been tested for herpesvirus-8? ❑ Yes ❑ No

93. What were the results of the herpesvirus-8 test? ❑ Positive ❑ Negative ❑ Unknown

94. Is the disease relapsed or refractory? ❑ Yes ❑ No

95. Will the requested drug be used as second-line therapy? ❑ Yes ❑ No

96. Will the requested drug be used as monotherapy? *If Yes, go back to #14* ❑ Yes ❑ No

Section F: Multicentric Castleman's Disease

97. Is the disease relapsed/refractory or progressive? ❑ Yes ❑ No

98. Will the requested drug be used as second-line therapy? ❑ Yes ❑ No

99. Will the requested drug be used as monotherapy? *If Yes, go back to #14* ❑ Yes ❑ No

Section G: Immunotherapy-Related Inflammatory Arthritis

100. Is the disease severe or refractory? ❑ Yes ❑ No

101. Has the patient tried and not responded to corticosteroids and anti-inflammatory agents? ***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

102. 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 ❑ No

103. What is the route of administration? ❑ Intravenous ❑ Subcutaneous

104. Does the prescribed dose exceed 162 mg? ❑ Yes ❑ No

105. Is the prescribed frequency more frequent than one dose every week? ❑ Yes ❑ No

Section H: Giant Cell Arteritis

106. Is this request for continuation of therapy with the requested drug? ❑ Yes ❑ No *If No, skip to #110*

107. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program? *If Yes or Unknown, skip to #110* ❑ Yes ❑ No ❑ Unknown

108. Has the patient achieved or maintained 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? ❑ Yes ❑ No

109. 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.*** *For any answer except None of the above, check the corresponding box and skip to #112*

❑ Headaches ❑ Scalp tenderness
❑ Jaw and/or tongue claudication ❑ Limb claudication
❑ Tenderness and/or thickening of superficial temporal arteries
❑ Constitutional symptoms (e.g., weight loss, fever, fatigue, night sweats)
❑ Acute visual symptoms (e.g., amaurosis fugax, acute visual loss, diplopia)
❑ Symptoms of polymyalgia rheumatica (e.g., shoulder and/or hip girdle pain)
❑ None of the above

110. Has the diagnosis been confirmed by temporal artery biopsy or cross-sectional imaging? *If Yes, skip to #112* ❑ Yes ❑ No

111. 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 ❑ No

112. What is the route of administration? ❑ Intravenous ❑ Subcutaneous

113. Does the prescribed dose exceed 162 mg? ❑ Yes ❑ No

114. Is the prescribed frequency more frequent than one dose every week? ❑ Yes ❑ No

Section I: Cytokine Release Syndrome

115. Has the patient been diagnosed with chimeric antigen receptor (CAR) T cell-induced cytokine release syndrome (CRS)? *If Yes, no further questions* ❑ Yes ❑ No

116. 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

Section J: Acute Graft versus Host Disease

117. 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 and skip to #119*** ❑ Yes ❑ No

118. 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, including response to therapy. If therapy is if not advisable, please attach documentation of clinical reason to avoid therapy.*** ❑ Yes ❑ No

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119. 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 ❑ No

120. What is the route of administration? ❑ Intravenous ❑ Subcutaneous

121. Does the prescribed dose exceed 8 mg per kg? ❑ Yes ❑ No

122. Is the prescribed frequency more frequent than one dose every 2 weeks? ❑ Yes ❑ No

Section K:Systemic Sclerosis-Associated Interstitial Lung Disease

123. Is this request for continuation of therapy with the requested drug? ❑ Yes ❑ No *If No, skip to #125*

124. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program? ❑ Yes ❑ No *If No, skip to #126* ❑ Unknown

125. 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 ❑ No

126. What is the route of administration? ❑ Intravenous ❑ Subcutaneous

127. Does the prescribed dose exceed 162 mg? ❑ Yes ❑ No

128. Is the prescribed frequency more frequent than one dose every week? ❑ Yes ❑ No

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