Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

# Actemra
## (tocilizumab)

| PHYSICIAN INFORMATION | | | PATIENT INFORMATION | | |
|---|---|---|---|---|---|
| * Physician's Name: | | | *Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.* | | |
| Specialty: | * DEA, NPI or TIN: | | * Patient Name: | | |
| Office Contact Person: | | | * Cigna ID: | * Date of Birth: | |
| Office Phone: | | | * Patient Street Address: | | |
| Office Fax: | | | City | State | Zip |
| Office Street Address: | | | Patient Phone: | | |
| City | State | Zip | | | |

**Urgency:**
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

**Medication requested:**
☐ Actemra 80mg/4ml vial ☐ Actemra 200mg/10ml vial ☐ Actemra 400mg/20ml vial
☐ Actemra 162mg/0.9ml syringe ☐ Actemra Actpen 162mg/0.9ml pen injector

Dose and Quantity: Duration of therapy: J-Code:

Frequency of administration: ICD10:
What is your patient's current weight? _____kg/lb
Is this a new start or continuation of therapy? If your patient has already begun treatment with drug samples of **Actemra**, please choose "new start of therapy". ☐ new start of therapy ☐ continued therapy

**If continued therapy:**
Has your patient had a good response to therapy with this drug (see below for examples)? ☐ Yes ☐ No

1. Giant Cell Arteritis: Improvement in serum markers (such as, C-reactive protein, erythrocyte sedimentation rate), resolution of fever, and/or reduced dosage of corticosteroids.
2. Inflammatory Arthritis Assoc. with Checkpoint Inhibitor therapy: Less joint pain, morning stiffness, or fatigue, improved function or activities of daily living, decreased soft tissue swelling in joints or tendon sheaths, improved laboratory values, reduced dosage of corticosteroids.
3. Polyarticular Juvenile Idiopathic Arthritis: Improvement in limitation of motion; less joint pain or tenderness; improved function or activities of daily living; decreased duration of morning stiffness or fatigue; reduced dosage of corticosteroids; decreased soft tissue swelling in joints or tendon sheaths; improved laboratory values.
4. Polymyalgia Rheumatica: Decreased shoulder, neck, upper arm, hip, or thigh pain or stiffness; improved range of motion; and/or decreased fatigue, improvement in serum markers (for example, C-reactive protein, and erythrocyte sedimentation rate), resolution of fever, or reduced dosage of corticosteroids.
5. Rheumatoid Arthritis: Less joint pain, morning stiffness, or fatigue; improved function or activities of daily living; decreased soft tissue swelling in joints or tendon sheaths; improved laboratory values; reduced dosage of corticosteroids.
6. Still's Disease: Resolution of fever, improvement in rash or skin manifestations, clinically significant improvement or normalization of serum markers (for example, C-reactive protein, erythrocyte sedimentation rate), reduced dosage of corticosteroids, less joint pain/tenderness, stiffness, or swelling, decreased fatigue and/or improved function or activities of daily living.
7. Systemic Juvenile Idiopathic Arthritis: Improvement in limitation of motion; less joint pain or tenderness; improved function or activities of daily living; decreased duration of morning stiffness or fatigue; reduced dosage of corticosteroids; decreased soft tissue swelling in joints or tendon sheaths; improved laboratory values. ☐ Yes ☐ No

(if no) Please provide clinical support for the continued use of **Actemra**:

(if continued therapy) Please provide the dates your patient has received **Actemra**:

*(Please note: there are different preferred products depending on your patient's plan. Please refer to the applicable Cigna health care professional resource [e.g. cignaforhcp.com] to determine benefit availability and the terms and conditions of coverage)*

**Where will this medication be obtained?**

☐ Accredo Specialty Pharmacy**
☐ Hospital Outpatient
☐ Retail pharmacy
☐ Other (please specify):
☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)

***Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1620 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

**Facility and/or doctor dispensing and administering medication:**

Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

**Where will this drug be administered?**

☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ Other (please specify):

***NOTE:** Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*

Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

**Diagnosis related to use:**

☐ Castleman disease (CD, giant lymph node hyperplasia, angiofollicular lymph node hyperplasia)
☐ Crohn's Disease
☐ Cytokine Release Syndrome (CRS) associated with Chimeric Antigen Receptor (CAR) T-Cell Therapy
☐ Giant Cell Arteritis (GCA) (temporal arteritis)
☐ Inflammatory Arthritis Associated with Checkpoint Inhibitor Therapy
☐ Management of Immunotherapy-Related Toxicities - Immune Checkpoint Inhibitor-Related Toxicities (not including inflammatory arthritis)
☐ Polyarticular Juvenile Idiopathic Arthritis (pJIA)
☐ Polymyalgia Rheumatica
☐ Rheumatoid Arthritis (RA)
☐ Still's disease
☐ Systemic Juvenile Idiopathic Arthritis (sJIA)
☐ other (please specify):

**Clinical Information:**

Besides the drug being requested, other biologics and tsDMARDs (targeted synthetic disease-modifying antirheumatic drugs) include Adbry, Cibinqo, Cimzia, Cosentyx, Enbrel, Entyvio, Humira, Ilumya, Infliximab (Avsola, Inflectra, Remicade, Renflexis), Kevzara, Kineret, Olumiant, Orencia, Otezla, Rinvoq, Rituximab (Riabni, Rituxan, Rituxan Hycela, Ruxience, Truxima), Siliq, Simponi Aria, Simponi, Skyrizi, Stelara, Taltz, Tremfya, Tysabri, Xeljanz, Xeljanz XR, Zeposia. Which of the following best describes your patient's situation?

☐ The patient is NOT taking any other biologic or tsDMARD at this time, nor will they in the future. The requested drug is the only biologic or tsDMARD the patient is/will be using.
☐ The patient is currently on another biologic or tsDMARD, but this drug will be stopped and the requested drug will be started.
☐ The patient is currently on another biologic or tsDMARD, and the requested drug will be added. The patient may continue to take both drugs together.
☐ The patient is currently on BOTH the requested drug AND another biologic or tsDMARD.
☐ Other

(if other/more than the requested drug) Please provide name of drug, dates taken and, if applicable, the clinical rationale for the combined use of the requested drug and another biologic to treat your patient's diagnosis.

**If Castleman disease:**

Does your patient have the multicentric or unicentric form of Castleman disease? ☐ multicentric ☐ unicentric ☐ unknown

(if multicentric) Does your patient have relapsed, refractory or progressive disease? ☐ Yes ☐ No

(if unicentric) Does your patient have relapsed or refractory disease? ☐ Yes ☐ No

(if unicentric) Is your patient HIV-negative? ☐ Yes ☐ No

(if unicentric) Is your patient human herpesvirus-8 (HHV-8)-negative? ☐ Yes ☐ No

**If CRS:**

Treatment is up to 4 doses, given at least every 8 hours apart. Has your patient received any doses yet? ☐ Yes ☐ No

(if yes) How many doses has your patient already received?

**If Giant Cell Arteritis:**

The covered alternative is ONE systemic corticosteroid (for example, prednisone). If your patient has tried this drug, please provide drug strength, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried this drug, please provide details why your patient can't try this alternative.

Per the information provided above, which of the following is true for your patient in regards to the covered alternative?
☐ The patient tried the alternative, but it didn't work well enough.
☐ The patient is able to try the alternative, but has not done so yet.
☐ The patient tried the alternative, but they did not tolerate it.
☐ The patient cannot try the alternative because of a contraindication to this drug.
☐ Other

Is this drug being prescribed by, or in consultation with, a rheumatologist or a prescriber who specializes in Giant Cell Arteritis? ☐ Yes ☐ No

**If Inflammatory Arthritis w/ Checkpoint Inhibitor:**

Has the patient developed inflammatory arthritis while receiving a checkpoint inhibitor ([for example, Keytruda (pembrolizumab IV infusion), Opdivo (nivolumab IV infusion), Yervoy (ipilimumab IV infusion), Tecentriq (atezolizumab IV infusion), Bavencio (avelumab IV infusion), Imfinzi (durvalumab IV infusion), or Libtayo (cemiplimab-rwlc intravenous infusion)]? ☐ Yes ☐ No

The covered alternative is ONE systemic corticosteroid (for example, methylprednisolone, prednisone). If your patient has tried this drug, please provide drug strength, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried this drug, please provide details why your patient can't try this alternative.

Per the information provided above, which of the following is true for your patient in regards to the covered alternative?
☐ The patient tried the alternative, but it didn't work well enough.
☐ The patient is able to try the alternative, but has not done so yet.
☐ The patient tried the alternative, but they did not tolerate it.
☐ The patient cannot try the alternative because of a contraindication to this drug.
☐ Other

The covered alternative is ONE nonsteroidal anti-inflammatory drug (NSAID) [for example, ibuprofen, naproxen]. If your patient has tried this drug, please provide drug strength, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried this drug, please provide details why your patient can't try this alternative.

Per the information provided above, which of the following is true for your patient in regards to the covered alternative?
☐ The patient tried the alternative, but it didn't work well enough.
☐ The patient is able to try the alternative, but has not done so yet.
☐ The patient tried the alternative, but they did not tolerate it.
☐ The patient cannot try the alternative because of a contraindication to this drug.

☐ Other
Is this drug being prescribed by, or in consultation with, a rheumatologist or an oncologist? ☐ Yes ☐ No

**If pJIA:**

Is this drug being prescribed by, or in consultation with, a rheumatologist or a prescriber who specializes in Polyarticular Juvenile Idiopathic Arthritis (PJIA)? ☐ Yes ☐ No

**If Polymyalgia Rheumatica:**

The covered alternative is ONE systemic corticosteroid (for example, prednisone). If your patient has tried this drug, please provide drug strength, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried this drug, please provide details why your patient can't try this alternative.

Per the information provided above, which of the following is true for your patient in regards to the covered alternative?
☐ The patient tried the alternative, but it didn't work well enough.
☐ The patient is able to try the alternative, but has not done so yet.
☐ The patient tried the alternative, but they did not tolerate it.
☐ The patient cannot try the alternative because of a contraindication to this drug.
☐ Other

Is this drug being prescribed by, or in consultation with, a rheumatologist or a prescriber who specializes in Polymyalgia Rheumatica?
☐ Yes ☐ No

**If RA:**

Has your patient already tried a biologic or targeted synthetic DMARD for Rheumatoid Arthritis [for example, Actemra, Cimzia, Enbrel, Humira, Infliximab (Avsola, Inflectra, Remicade, Renflexis), Kevzara, Kineret, Olumiant, Orencia, Rinvoq, Rituximab (Riabni, Rituxan, Rituxan Hycela, Ruxience, Truxima), Simponi, Simponi Aria, Xeljanz tablets, Xeljanz XR]? ☐ Yes ☐ No

The covered alternative is conventional synthetic disease-modifying anti-rheumatic drug (csDMARD) therapy [for example, methotrexate, hydroxychloroquine, leflunomide, sulfasalazine]. If your patient has tried this alternative, please provide drug strength, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried this drug, please provide details why your patient can't try this alternative.

Per the information provided above, which of the following is true for your patient in regards to the covered alternative?
☐ The patient tried at least ONE csDMARD, but it didn't work well enough.
☐ The patient is able to try the alternative, but has not done so yet.
☐ The patient tried csDMARD therapy, but they did not tolerate it.
☐ The patient cannot try csDMARD therapy because of a contraindication.
☐ Other

Is this drug being prescribed by, or in consultation with, a rheumatologist or a prescriber who specializes in rheumatoid arthritis?
☐ Yes ☐ No

**If sJIA:**
Is this drug being prescribed by, or in consultation with, a rheumatologist or a prescriber who specializes in Systemic Juvenile Idiopathic Arthritis (SJIA)? ☐ Yes ☐ No

**If Still's disease:**
Is this drug being prescribed by, or in consultation with, a rheumatologist or a prescriber who specializes in Still's Disease?
☐ Yes ☐ No
Has your patient already tried a biologic for Still's Disease? ☐ Yes ☐ No

(if no biologic) The covered alternative is ONE corticosteroid (for example, prednisone). If your patient has tried this drug, please provide drug strength, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried this drug, please provide details why your patient can't try this alternative.

Per the information provided above, which of the following is true for your patient in regards to the covered alternative?
☐ The patient tried the alternative, but it didn't work well enough.
☐ The patient is able to try the alternative, but has not done so yet.
☐ The patient tried the alternative, but they did not tolerate it.
☐ The patient cannot try the alternative because of a contraindication to this drug.
☐ Other

(If no biologic) The covered alternative is ONE conventional synthetic disease-modifying anti-rheumatic drug (csDMARD) [for example, methotrexate]. If your patient has tried this drug, please provide drug strength, date(s) taken and for how long, and what the documented results were of taking this drug, including any intolerances or adverse reactions your patient experienced. If your patient has NOT tried this drug, please provide details why your patient can't try this alternative.

Per the information provided above, which of the following is true for your patient in regards to the covered alternative?
☐ The patient tried the alternative for at least 2 months, but it didn't work well enough.
☐ The patient is able to try the alternative, but has not done so yet.
☐ The patient tried the alternative, but they did not tolerate it.
☐ The patient cannot try the alternative because of a contraindication to this drug.
☐ Other

**Additional Information:** *Please provide clinical rationale for the use of this drug for your patient (pertinent patient history, alternatives tried, any inability to use alternatives above or standard therapy, etc). Please include drug name(s), date(s) taken and for how long, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced.*

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

**Prescriber Signature:**_____ **Date:**_____

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