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:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City	State	Zip
City	State	Zip	Patient Phone:		

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 (such as improvement or remission)? ☐ Yes ☐ No
(if no) Please provide clinical support for the continued use of **Actemra**:

Which applies to your patient?
☐ patient is established on this drug with previous approval by Cigna
☐ patient is established on this drug with previous approval by another health plan
☐ patient is established on this drug with regular use for more than 1 year
☐ patient was previously established on this drug, and is restarting after a break in 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**
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor
***Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1640 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):

NOTE: *Per some Cigna plans, infusion of medication MUST occur in the lowest cost, medically appropriate setting*
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Is this infusion occurring in a facility affiliated with hospital outpatient setting? ☐ Yes ☐ No

If yes- Is this patient a candidate for re-direction to an alternate setting after 1-2 infusions (such as AIS, MDO, home) with assistance of a Specialty Care Option 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)
☐ chimeric antigen receptor (CAR) T cell-induced cytokine release syndrome (CRS)
☐ cytokine release syndrome (CRS) associated with COVID-19
☐ inflammatory arthritis associated with checkpoint inhibitor therapy
☐ management of other immune checkpoint inhibitor-related toxicities (not including inflammatory arthritis)
☐ polyarticular Juvenile Idiopathic Arthritis (pJIA)
☐ systemic Juvenile Idiopathic Arthritis (sJIA)
☐ rheumatoid arthritis (RA)
☐ Still's disease
☐ other (please specify):

Clinical Information:

Besides the drug being requested, other biological drugs include Cimzia, Cosentyx, Enbrel, Entyvio, Humira, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Rinvoq, Rituxan, Siliq, Simponi/Simponi Aria, Stelara, Taltz, Tremfya, Tysabri, and Xeljanz/Xeljanz XR. Which of the following best describes your patient's situation?

☐ The patient is NOT taking any other biological at this time, nor will they in the future. The requested drug is the only biological the patient is/will be using.
☐ The patient is currently on another biological, but this drug will be stopped and the requested drug will be started.
☐ The patient is currently on another biological, 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 biological.
☐ other/unknown

(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 RA, Still's) Has the patient already received a biologic for their condition? ☐ Yes ☐ No

If Inflammatory Arthritis w/ Checkpoint Inhibitor:

Does the patient have documented failure or intolerance, contraindication per FDA label, intolerance, or is not a candidate for ONE steroid (for example, methylprednisolone, prednisone)? ☐ Yes ☐ No

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)]? ☐ Yes ☐ No

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

If pJIA:

Is there documentation that your patient either has had failure, inadequate response OR intolerance to any of the following? (check all that apply): ☐ Enbrel ☐ Humira ☐ Inflectra ☐ Orencia ☐Remicade ☐ Renflexis
☐ Other: _____

Please provide drug name(s), date(s) taken and what the documented results were for each drug tried:

Is there documentation that your patient has a contraindication per FDA label to OR is not a candidate for any of the following? (check all that apply): ☐ Enbrel ☐ Humira ☐ Inflectra ☐ Orencia ☐Remicade ☐ Renflexis
☐ Other: _____

Please explain any contraindication OR reason why your patient is not a candidate for any drugs that were checked off:

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 RA:

Is there documentation that your patient either has had failure, inadequate response or intolerance OR has a contraindication per FDA label OR is not a candidate for one disease-modifying anti-rheumatic drug (DMARD) (for example: methotrexate, leflunomide, sulfasalazine)? ☐ Yes ☐ No

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

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 CAR-T cell-induced CRS) Does your patient have a severe or life-threatening case? ☐ 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 there documentation that your patient had failure or intolerance, contraindication per FDA label, intolerance, or is not a candidate to ONE corticosteroid (for example, prednisone)? ☐ Yes ☐ No

Is there documentation that your patient had failure or intolerance, contraindication per FDA label, intolerance, or not a candidate to ONE conventional synthetic disease-modifying antirheumatic drug (DMARD) (for example, methotrexate) GIVEN FOR AT LEAST 2 MONTHS? ☐ Yes ☐ No

Is this drug being prescribed by, or in consultation with, a rheumatologist or a prescriber who specializes in Still's Disease? ☐ Yes ☐ No

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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