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Salt Lake City, UT 84130-0192
801-442-4912 or 800-442-3129
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selecthealth℠

PREAUTHORIZATION FORM

Actemra™
(Tocilizumab)

Therapeutic use: Treatment of moderate to severe rheumatoid arthritis in patients who had an inadequate response to one or more tumor-necrosis-factor antagonist therapies and for patients 2 and older with active systemic juvenile idiopathic arthritis.

Quantity Limit: 800 mg per injection

Authorization Period: 1 year

Patient's name _____

Patient's ID# | | | | | | | | | | DOB | | | / | | | / | | | | |

ICD-9 | | | | | | | | | | | | _____

Physician's name_____

Physician's Ph# (| | |) | | | - | | | | | Fax# | | | - | | | |

Physician's signature_____ Date signed | | / | | / | | | | |

Supervising Physician's name_____ (Required if requesting provider is a nurse practitioner or physician assistant)

Please check "Yes" or "No" or answer the following questions:			
1a.	Has the adult patient been diagnosed with moderate to severe active RA (meeting the American College of Rheumatology criteria)?	❑ Yes	❑ No
1b.	Has the patient 2 years of age and older been diagnosed with active juvenile rheumatoid arthritis?	❑ Yes	❑ No
2.	Is the prescribing physician a rheumatologist? If no, has the patient consulted a rheumatologist who recommended this treatment?	❑ Yes	❑ No
3.	Does the patient have persistent active disease and been treated for three months (less, if therapy discontinued due to complications) with one of the treatments listed below? a) Methotrexate >15 mg/week b) Leflunomide (Arava ™) 100 mg daily on days 1-3, then 10-20 mg po qd c) Hydroxychloroquine 200 mg po bid for at least three months d) Sulfasalazine 1 g po bid-tid e) Injectable gold salts >25 mg im q2-4 weeks f) Oral gold 3 mg po qd-bid g) Azathioprine >50 mg po h) D-penicillamine >250 mg po qd i) Cyclosporine >2.5 mg/kg/day	❑ Yes	❑ No
4.	Has the patient failed treatment with a TNF antagonist (Enbrel, Remicade, or Humira)?	❑ Yes	❑ No
Actemra will not be covered in combination with a TNF antagonist or Kineret due to a lack of enhanced efficacy, and a higher risk of serious infection.			

This form is intended for SelectHealth members only. All requests for preauthorization should be sent via fax to 1-801-442-3006.
Missing, inaccurate, or incomplete information may cause a delay or denial of authorization.

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