

BlueShield. TOCILIZUMAB Federal Employee Program. PRIOR APPROVAL REQUEST

Send completed form to: Service Benefit Plan Prior Approval P.O. Box 52080 MC 139 Phoenix, AZ 85072-2080 Attn. Clinical Services

Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

□ NO – this is **INITIATION** of therapy, please answer the questions on **PAGES 6-7**

□ YES – this is a PA renewal for CONTINUATION of therapy, please answer the questions on PAGES 8-9

Patient Information (required)			Provider Information (required)			
Date:			Provider Name:			
Patient Name:			Specialty:			
Date of Birth:	Sex: □Ma	le G Female	Office Phone: Office Fax:			
Street Address:			Office Street Address:			
City:	State:	Zip:	City:	State:	Zip:	
Patient ID: R	1 1 1	1 1	Physician Signature:			
		PHYSICIAN	COMPLETES			
1. Is this medication being us *The FDA approved ements should be billed under the	sed to treat COVID- gency use for Actem	-19? □Yes □N			vitalized patients. This	
2. Will this medication be g	iven by IV infusio	n or by subcutan	eous (SC) injection?	Please select answer	below:	
□ IV infusion: Has the pa Please select answer belo		nedication continu	iously for the last 6 mo	onths, excluding samp	oles?	
\square NO – this is INITI	ATION of therapy	, please answer th	e questions on PAGES	<u>S 2-3</u>		
\Box YES – this is a PA	renewal for CONT	TINUATION of the	herapy, please answer	the questions on PAG	<u>E 4-5</u>	
☐Subcutaneous injection Please select answer below		een on this medic	ation continuously for	the last 6 months , exc	cluding samples?	

FOR CLAIMS ADJUDICATED THROUGH THE PHARMACY BENEFIT:
A SUBCUTANEOUS INJECTION REQUEST FOR STANDARD OR BASIC OPTION PATIENTS WITH A DIAGNOSIS OF POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS OR RHEUMATOID ARTHRITIS REQUIRES PAGE 10 TO BE COMPLETED

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TOCILIZUMAB

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Patient Information (required)			Provider Information (required)			
Date:			Provider Name:			
Patient Name:			Specialty:		NPI:	
Date of Birth:	Sex: □Male	□Female	Office Phone:		Office Fax:	
Street Address:	_		Office Street Address:			
City:	State:	Zip:	City:	St	ate:	Zip:
Patient ID: R		1	Physician Signature:			
IX L	P	HYSICIAN (COMPLETES			
		IV inje	ection			
	NOTE: Form m	•	d in its entirety for prod	cessing		
Please select medication:						
☐ Actemra (tocilizumab) 80mg/4ml IV injection		temra (tocilizur Img/10ml IV in			ra (tocilizum g/20ml IV inje	
☐ Tyenne (tocilizumab-aazg) 80mg/4ml IV injection	□Tye	enne (tocilizum)mg/10ml IV in	ab-aazg)	□Tyenn	e (tocilizuma g/20ml IV inje	ıb-aazg)
**Check www.fepblue.org/formulary to					<u> </u>	
1. Has the patient been on this me	edication continuou	usly for the last	6 months , excluding sai	mples? Pl e	ease select answ	ver helow:
☐ YES – this is a PA renewal		•	-	-		,
□ NO – this is INITIATION			•	_		
2. Is this request for brand or gen	eric? □Brand □	Generic				
3. Has the patient had a recent tes	st for a latent tuber	culosis (TB)?	□Yes* □ No			
If YES, was the result of the	test positive or ne	gative for TB in	fection? Negative	□Positive	e	
*If POSITIVE, has the pat	ient completed trea	atment or is the	patient currently receivi	ng treatm	ent for latent 7	ΓB? □Yes □No
4. Is the patient at risk for hepatit * <i>If YES</i> , has HBV infection 1				or the HB	SV infection?	□Yes □No
5. Does the patient have any activ	e infections includ	ding tuberculosis	s (TB) and hepatitis B v	irus (HBV	/)? □Yes □1	No
6. Will the patient be given live v	accines while on the	his therapy?	Yes □No			
7. Will this medication be used in synthetic DMARD? □Yes*		another biologi	c *disease-modifying ar	ntirheuma	tic drug (DM	ARD) or targeted
*If YES, please specify med	lication:					
*DMARDs: Avsola, Bimzelx Olumiant, Orencia, Otezla, I Spevigo, Stelara, Taltz, Tren	Remicade, Renflexis	, Riabni, Rinvoq,	Rituxan, Ruxience, Siliq,			
8. What is the patient's diagnosis	?					
☐Cytokine Release Syndrome	(CRS)					
a. Does the patient have c	•	•		es □N	0	
b. Is the syndrome consider		_				
c. Does the prescriber agree administration? □Yes	□No			y subcuta	neous	
d. What is the patient's we	_					
□ Less than 30kg (66ll dose of 12mg/kg with		-	lminister this medication are at least 8 hours apa			ed maintenance
☐ Greater than or equ maintenance dose of			riber agree to administe ses administered at least			n the FDA labeled ☐No



☐ Other diagnosis (please specify): _

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ysician portion and submit this completed form.	PAGE 3 - PHYSICIA	Fax: 1-877-37 AN COMPLETES	
Patient Name:	DOB:	Patient ID: R	
•	•	nse to at least a 3 month trial of corticosteroids? □Yes □N in the FDA labeled maintenance dose of 6mg/kg every	O
☐ Multicentric Castleman's dis a. Has the patient's disease b. Does the prescriber agree c. Is this medication being p	progressed following treatment of to only give this medication as a prescribed as a single agent therape to administer this medication wi	f relapsed/refractory or progressive disease? □Yes □No n IV infusion and not by subcutaneous administration? □Ye by? □Yes □No thin the maintenance dose of 8mg/kg every 2 weeks? □Yes	es □No
a. Is the patient's disease reb. Is the patient HIV negationc. Is the patient human herpd. Is this medication being patient	lapsed or refractory?		vas □No
1 0	to administer this medication with thic Arthritis (pJIA)	thin the maintenance dose of 8mg/kg every 4 weeks? Yes	
-		ventional DMARD? □Yes □No* That an inadequate treatment response to a 3 month trial of	at least
they had an inadequate tre		Does the patient have an intolerance or contraindication or h MARD or targeted synthetic DMARD? □Yes □No	ave
of 10mg/kg every 4 we	eeks? 🗆 Yes 🗆 No	dminister this medication within the FDA labeled maintenant riber agree to administer this medication within the FDA lab	
maintenance dose of 8		No	serea
b. Does the patient have a co		atoid arthritis? □Yes □No ventional DMARD? □Yes □No* vhad an inadequate treatment response to a 3 month trial of	at least
	hrough the pharmacy benefit: I	Does the patient have an intolerance or contraindication or h MARD or targeted synthetic DMARD? □Yes □No	ıave
d. Does the prescriber agree to 4 weeks? □Yes □No	o administer this medication within	n the FDA labeled maintenance dose of 8mg/kg every	
☐ Systemic Juvenile Idiopathic a. Is the patient's arthritis ac			
If NO, has the patient e		ast a 3 month trial of methotrexate or leflunomide? □Yes response to at least a 2 week trial of corticosteroids? □Yes	□No □No
•	s): Does the prescriber agree to ac	lminister this medication within the FDA labeled maintenan	ice dose
	ll to 30kg (66lbs): Does the presc mg/kg every 2 weeks? □Yes □	riber agree to administer this medication within the FDA lab No	beled



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☐ Polyarticular Juvenile Idiopathic Arthritis (PJIA)

a. What is the patient's weight? Please select answer below:

dose of 10mg/kg every 4 weeks? □Yes □No

maintenance dose of 8mg/kg every 4 weeks? □Yes □No

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physician portion and submit this completed	l form.	· · · · · ·			Fax:	<u>1-877-378</u>	<u> -4727</u>
Patient Inf	Cormation (required)		Provider Information (required)				
Date:			Provider Name:				
Patient Name:			Specialty: NPI:		NPI:		
Date of Birth:	Sex: □Male	□Female	☐Female Office Phone:		Office Fax:		
Street Address:			Office Street Addre	ss:			
City:	State:	Zip:	City:		State:	Zip:	
Patient ID: _			Physician Signature	::			
RLIIII							
		PHYSICIAN C		DENIEVA	'AT)		
•	CONTINUATIO		`	KENEW	AL)		
		IV Inje					
Please select medication:	NOTE: Form n	nust be completed	l in its entirety for	processing			
☐ Actemra (tocilizumab)	□Ac	etemra (tocilizum	ab)	□Actei	nra (tocilizumal	b)	
80mg/4ml IV injection	20	0mg/10ml IV inj	ection	400m	400mg/20ml IV injection		
					enne (tocilizumab-aazg) Omg/20ml IV injection		
**Check www.fepblue.org/formul					9 1 911		
1. Has the patient been on th	is medication continuo	usly for the last 6	months, excluding	samples? Pl	ease select answer	below:	
\square NO – this is INITIAT		•	•	<u>*</u>			
☐ YES – this is a PA rene	ewal for CONTINUA	ΓΙΟΝ of therapy,	please answer the	question belo	ow:		
2. Is this request for brand or	r generic? □Brand	□Generic					
3. Has the patient's condition	n improved or stabilize	ed with therapy?	□Yes □No				
4. Does the patient have any	active infections inclu	ding tuberculosis	(TB) and hepatitis	B virus (HB	V)? □Yes □No	0	
5. Will the patient be given l	ive vaccines while on	this therapy?	es □No				
6. Will this medication be us synthetic DMARD? □Y6		h another biologic	*disease-modifyin	ig antirheum	atic drug (DMAI	RD) or targ	eted
*If YES, please specify	medication:						
Olumiant, Orencia, Ot	mzelx, Cimzia, Cosentyx ezla, Remicade, Renflexi Tremfya, Truxima, Xelj	is, Riabni, Rinvoq, I	Rituxan, Ruxience, S				
7. What is the patient's diagram	nosis?						
☐Giant cell arteritis							
a. Does the prescriber ag 4 weeks? □Yes □No	-	nedication within th	ne FDA labeled mair	ntenance dose	e of 6mg/kg every	•	
☐ Multicentric Castleman a. Does the prescriber a		s medication within	n the maintenance of	lose of 8mg/	kg every 2 week	s? □Yes	□No
☐ Unicentric Castleman's	s disease						
a. Does the prescriber	agree to administer this	s medication within	n the maintenance of	dose of 8mg/	kg every 4 week	s? □Yes	□No

PLEASE PROCEED TO PAGE 5 FOR ADDITIONAL DIAGNOSES

□ Less than 30kg (66lbs): Does the prescriber agree to administer this medication within the FDA labeled maintenance

☐ Greater than or equal to 30kg (66lbs): Does the prescriber agree to administer this medication within the FDA labeled

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PAGE 5 – PHYSICIAN COMPLETES						
Patient Name:	DOB:	Patient ID: R				
☐ Rheumatoid Arthritis (RA)						
a. Does the prescriber agree to ac4 weeks? □Yes □No	lminister this medication within	the FDA labeled maintenance dose of 8mg/kg every				
☐ Systemic Juvenile Idiopathic Artl	nritis (SJIA)					
a. What is the patient's weight?	Please select answer below:					
☐ Less than 30kg (66lbs): dose of 12mg/kg every 2	1 2	lminister this medication within the FDA labeled maintenance				
_	30kg (66lbs): Does the presc /kg every 2 weeks? □Yes □	riber agree to administer this medication within the FDA labeled ${f 1}$ No				
☐ Other diagnosis (<i>please specify</i>):						

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Patient Information (required)		Provider Information (required)				
D	Pate:			Provider Name:		
P	atient Name:			Specialty:	NPI:	
D	Date of Birth:	Sex: ☐Male ☐Female		Office Phone:	Office Phone: Office Fax:	
S	treet Address:			Office Street Address:		
C	City:	State:	Zip:	City:	State:	Zip:
P	atient ID:			Physician Signature:		I
	N	P	HYSICIAN C	OMPLETES		
	FOR C			GH THE PHARMACY BEN	EFIT:	
	For Standard and Basic Option pa are preferred products. Patien	atients Enbrel, Hui	mira including pr	referred Humira biosimilars,	Rinvoq, and Xe	
				s Injection		- 10 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1
	***Check			which medication is part of the p	oatient's benefit	
		NOTE: Form m	ust be completed	d in its entirety for processi	ing	
1.	Has the patient been on this med	dication continuous	sly for at least 6	months, excluding samples	s? Please select a	answer helow:
	☐ YES – this is a PA renewal f		•		_	
	□NO – this is INITIATION of			•		
2.	Is this request for brand or gene		Generic			
	Has the patient been tested for l			□ No		
	If YES, was the result of the				ositive	
	*If POSITIVE, has the pati	-	_	•		ent TB? □Yes □No
4.	Is the patient at risk for hepatiti	•	-	•		
	*If YES, has HBV infection b				ne HBV infection	on? □Yes □No
5.	Does the patient have any active					
6.	Will the patient be given live va	accines while on th	his therapy?	Yes □No		
7.	Will this medication be used in a synthetic DMARD? □Yes*		another biologic	*disease-modifying antirhe	eumatic drug (D	OMARD) or targeted
	*If YES, please specify medi	ication:				
	· · · · · · · · · · · · · · · · · · ·	Remicade, Renflexis,	, Riabni, Rinvoq,	Humira or a Humira biosimil Rituxan, Ruxience, Siliq, Sim ymfentra.		
8.	What is the patient's diagnosis?					
	☐Giant cell arteritis					
	a. Has the patient experience	ced an inadequate	treatment respon	nse to at least a 3 month tria	1 of corticostero	oids? □Yes □No
	b. Does the prescriber agree every week? □Yes □N		nedication within	the FDA labeled maintenand	ce dose of 162m	g
	□Rheumatoid Arthritis (RA)					
	a. Standard/Basic Option Humira or a Humira bios			through the pharmacy beaz/Xeljanz XR? □Yes □	<u>nefit</u> : Has the pa No*	atient tried and failed
	If NO, would you lik	te to switch the pat	tient to a preferre	ed product? □Yes □No)	
	*If YES, select the p	preferred product:	☐Humira/pre	ferred biosimilar □Enbre	l □Rinvoq	□Xeljanz/Xeljanz XR
	b. Does the patient have m	oderately to severe	ely active rheum	atoid arthritis?	No	
	c. Does the patient have a	contraindication to	at least one con	ventional DMARD?	s □No*	
	*If NO, does the patie least one conventional			y had an inadequate treatme	ent response to a	a 3 month trial of at
	d. Does the prescriber agree		medication withir	n the FDA labeled maintenan	ce dose of 162m	ıg

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PAGE 7 – PHYSICIAN COMPLETES					
Patient Name:	_ DOB:	Patient	ID: R		
☐Polyarticular Juvenile Idiopathic Arthri	tis (pJIA)				
			nacy benefit: Has the patient tried and faile		
Humira or Humira biosimilar, Enb		•			
*If NO, would you like to switch		•			
*If YES, select the preferred	product: ☐Humira/pr	referred biosimilar	□Enbrel □Rinvoq/LQ □Xeljan:		
b. Is the patient's arthritis active? \Box	Yes □No				
c. Does the patient have a contraindic	ation to at least one c	onventional DMARD?	? □Yes □No*		
*If NO, does the patient have an least one conventional DMARD		ney had an inadequate	treatment response to a 3 month trial of at		
d. What is the patient's weight? Pleas	e select answer below:				
☐ Less than 30kg (66lbs): Does the of 162mg once every 3 weeks?		administer this medicat	tion within the FDA labeled maintenance of		
☐ Greater than or equal to 30kg maintenance dose of 162mg once			ister this medication within the FDA labeled		
□Systemic Juvenile Idiopathic Arthritis (sJIA)				
a. Is the patient's arthritis active?	Yes □No				
b. Has the patient experienced an inac	dequate response to a	t least a 3 month trial o	of methotrexate or leflunomide? \(\square\)Yes \(\square\)		
• •			a 2 week trial of corticosteroids? □Yes □		
c. What is the patient's weight? <i>Pleas</i>	e select answer below:				
1	ne prescriber agree to	administer this medicat	tion within the FDA labeled maintenance d		
☐ Greater than or equal to 30kg maintenance dose of 162mg once			ister this medication within the FDA labele		
□Systemic Sclerosis-Associated Interstiti	al Lung Disease (SSc	:-ILD)			
a. Does the prescriber agree to only g	ive this medication as	a subcutaneous dose a	and not by IV administration? \(\sigma\)Yes \(\sigma\)		
b. Does the prescriber agree to adminis every week? □Yes □No	ter this medication wit	hin the FDA labeled ma	aintenance dose of 162mg		
☐ Other diagnosis (please specify):					

FOR CLAIMS ADJUDICATED THROUGH THE PHARMACY BENEFIT: A SUBCUTANEOUS INJECTION REQUEST FOR STANDARD OR BASIC OPTION PATIENTS WITH A DIAGNOSIS OF POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS OR RHEUMATOID ARTHRITIS **REQUIRES PAGE 10 TO BE COMPLETED**

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Data	Paulent Infor	rmation (required)		Drovidos M-		nformation	(required)	
Date:				Provider Nam	le.	T		
Patient Name:				Specialty:		NPI:	NPI:	
Date of Birth:		Sex: □Male	□Female	Office Phone:		Office Fax:		
Street Address				Office Street	Address:	•		
City:		State:	Zip:	City:		State:	Zip:	
Patient ID:				Physician Sign	nature:			
_	 -	P	HYSICIAN C	COMPLETES	S			
	l and Basic Optio	R CLAIMS ADJUDIC on patients Enbrel, Hu ntients who switch to a	mira including p	referred Humii	ra biosimilars, R	invoq, and Xelja		
	C	ONTINUATIO	ON OF TH	ERAPY (I	PA RENEV	VAL)		
		Sı	ıbcutaneou	ıs Injectio	n			
	**Che	eck www.fepblue.org/forn	nulary to confirm v	which medication	is part of the patie	ent's benefit		
		NOTE: Form m	ust be complete	d in its entiret	y for processing			
□ NO – thi	s is INITIATIO	medication continuous N of therapy, please a al for CONTINUAT	answer the quest	tions on PAGE	E 6		wer below:	
			Generic	, prouse unswer	a une questions s			
•	_	mproved or stabilized		□Yes □No				
•		etive infections includ	1.		atitis B virus (H	BV)? □Yes □	l No	
•	•	e vaccines while on the	•	•	— (,		
	edication be used MARD? □Yes*	l in combination with ^k □No	another biologi	c *disease-moo	difying antirheu	matic drug (DM	IARD) or targeted	
•		nedication:						
Olumia	nt, Orencia, Otezlo	elx, Cimzia, Cosentyx, a, Remicade, Renflexis, remfya, Truxima, Xelja	Riabni, Rinvoq,	Rituxan, Ruxie				
7. What is the	patient's diagnos	sis?						
☐Giant cel	arteritis							
	the prescriber ag ? □Yes □No	ree to administer this I	nedication with	in the FDA labe	eled maintenance	dose of 162mg	every	
•	☐ Systemic Juvenile Idiopathic Arthritis (SJIA)							
		weight? Please select a						
		66lbs): Does the presence every 2 weeks? \Box		dminister this	medication with	in the FDA lab	eled maintenance	
		equal to 30kg (66lbs) of 162mg once every			administer this	medication with	hin the FDA labeled	
□Systemic	Sclerosis-Assoc	iated Interstitial Lung	Disease (SSc-I	LD)				
	the prescriber ag	ree to administer this 1	medication with	in the FDA labe	eled maintenance	dose of 162mg	every	

PLEASE PROCEED TO PAGE 9 FOR ADDITIONAL DIAGNOSES

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Patient Name:	DOB:	Patient ID: R _			
☐ Polyarticular Juvenile Idiopat	nic Arthritis (PJIA)				
	patient, <u>for claims adjudicated th</u> milar, Enbrel, Rinvoq/LQ, or Xelj		nefit: Has	the patient tried	and failed
* If NO , would you like	to switch the patient to a preferred	d product? □Yes* □No)		
*If YES, please sele	ect the preferred product:	ra/preferred biosimilar	⊒Enbrel	□Rinvoq/LQ	□Xeljanz
b. What is the patient's weigh	ght? Please select answer below:				
	s): Does the prescriber agree to advery 3 weeks? □Yes □No	minister this medication w	ithin the F	FDA labeled main	ntenance
-	al to 30kg (66lbs): Does the prescr 62mg every 2 weeks? \square Yes	•	is medicat	tion within the F	DA labeled
☐ Rheumatoid Arthritis (RA)					
	patient, <u>for claims adjudicated the</u> milar, Enbrel, Rinvoq, or Xeljanz/			the patient tried	and failed
* If NO , would you lik	e to switch the patient to a preferre	ed product? □Yes* □N	O		
*If YES, select the	preferred product: Humira/prefe	erred biosimilar DEnbrel	□Rinvoq	□Xeljanz/Xelj	anz XR
b. Does the prescriber agree t week? □Yes □No	o administer this medication within	the FDA labeled maintenar	nce dose of	f 162mg every	
☐ Other diagnosis (please specify) :				

FOR CLAIMS ADJUDICATED THROUGH THE PHARMACY BENEFIT:
A SUBCUTANEOUS INJECTION REQUEST FOR STANDARD OR BASIC OPTION PATIENTS WITH A DIAGNOSIS
OF POLYARTICULAR JUVENILE IDIOPATHIC ARTHRITIS OR RHEUMATOID ARTHRITIS
REQUIRES PAGE 10 TO BE COMPLETED

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Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Name:	DOB:	Patient ID: R	
A SUBCUTANEOUS INJECT	TION REQUEST FOR STANDA	OUGH THE PHARMACY BENEFIT: ARD OR BASIC OPTION PATIENTS WI C ARTHRITIS OR RHEUMATOID ART TO BE COMPLETED	
Please select the diagnosis and	answer the following questions:		
☐ Rheumatoid arthritis (RA)		
		or have they had an inadequate treatment resisimilar, Enbrel, Rinvoq, or Xeljanz/Xeljanz	•
		tibody formation/lupus-like syndrome, or a histor ting disorder such as multiple sclerosis, Guillain	
Please select answer: \square	IYes □No*		
*If NO, is there a clinical	l reason for not trying ONE of the	e preferred medications? □Yes □No	
☐Polyarticular juvenile idio	pathic arthritis (pJIA)		
		or have they had an inadequate treatment resisimilar, Enbrel, Rinvoq/LQ, or Xeljanz?	sponse to ONE of the
		ibody formation/lupus-like syndrome, or a histor ting disorder such as multiple sclerosis, Guillain	
Please select answer: \square	IYes □No*		
*If NO, is there a clinical	l reason for not trying ONE of the	e preferred medications? □Yes □No	

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