

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: NPI:		
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 COVIDegency use for Actem	-19? □Yes □N			pitalized patients. This
2. Will this medication be g	iven by IV infusio	n or by subcutan	eous (SC) injection?	Please select answer l	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 Inform	Patient Information (required) Provider Information (required)		equired)			
Date:			Provider Name:			
Patient Name:			Specialty:		NPI:	
Date of Birth:	Sex: □Male	□Female	Office Phone:	chone: Office Fax:		
Street Address:			Office Street Address:			
City:	State:	Zip:	City: State: Zip:		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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PAGE 3 - PHYSICIAN COMPLETES					
Patient Name:	DOB:	Patient ID: R			
		onse to at least a 3 month trial of corticosteroids? □Yes □No hin the FDA labeled maintenance dose of 6mg/kg every)		
☐ Multicentric Castleman's disease a. Has the patient's disease progre b. Does the prescriber agree to onl c. Is this medication being prescrib	y give this medication as a ped as a single agent thera	of relapsed/refractory or progressive disease? □Yes □No an IV infusion and not by subcutaneous administration? □Yes py? □Yes □No rithin the maintenance dose of 8mg/kg every 2 weeks? □Yes			
 a. Is the patient's disease relapsed b. Is the patient HIV negative? c. Is the patient human herpesvirus d. Is this medication being prescrite. e. Does the prescriber agree to only 	Yes \(\subseteq No \) s-8 negative? \(\subseteq Yes \) bed as a single agent thera begin y give this medication as a chinister this medication with thritis (pJIA)	No No npy? □Yes □No an IV infusion and not by subcutaneous administration? □Ye ithin the maintenance dose of 8mg/kg every 4 weeks? □Yes			
 b. Does the patient have a contraint *If NO, does the patient have one conventional DMARD? c. For claims adjudicated throug they had an inadequate treatment d. What is the patient's weight? Plant in the patient's weight? 	dication to at least one cor an intolerance or have the Tyes Tho h the pharmacy benefit: a response to a biologic Di ase select answer below: as the prescriber agree to a	nventional DMARD? □Yes □No* y had an inadequate treatment response to a 3 month trial of at Does the patient have an intolerance or contraindication or ha MARD or targeted synthetic DMARD? □Yes □No administer this medication within the FDA labeled maintenance	ive		
maintenance dose of 8mg/kg □Rheumatoid Arthritis (RA) a. Does the patient have moderately b. Does the patient have a contraint *If NO, does the patient have one conventional DMARD? □ c. For claims adjudicated throug they had an inadequate treatment d. Does the prescriber agree to admin	every 4 weeks? Yes y to severely active rheum dication to at least one cor an intolerance or have the Yes No h the pharmacy benefit: tresponse to a biologic Di	criber agree to administer this medication within the FDA label No natoid arthritis? □Yes □No neventional DMARD? □Yes □No* y had an inadequate treatment response to a 3 month trial of at Does the patient have an intolerance or contraindication or ha MARD or targeted synthetic DMARD? □Yes □No in the FDA labeled maintenance dose of 8mg/kg every	t least		
*If NO, has the patient experient c. What is the patient's weight? Ple □ Less than 30kg (66lbs): Doe of 12mg/kg every 2 weeks?	□Yes □No nadequate response to at le ced an inadequate treatmen ase select answer below: st the prescriber agree to a □Yes □No kg (66lbs): Does the pres	at response to at least a 2 week trial of corticosteroids? "Yes distributed this medication within the FDA labeled maintenance of the corticosteroids of the c			



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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:	1-877-378	3-4727
Patient Inf	formation (required)		P	rovider In	formation (red	quired)	
Date:			Provider Name:				
Patient Name:			Specialty:		NPI:		
Date of Birth: Sex: □Male □Female Street Address:		□Female	Office Phone:		Office Fax:		
		Office Street Adda	ress:				
City:	State: Zip: City:			State:	Zip:		
Patient ID:			Physician Signatur	re:			
R	<u> </u>	PHYSICIAN (
				DENIEW	7 A T)		
•	CONTINUATIO		`	KENEW	(AL)		
		IV Inj					
Please select medication:	NOTE: Form n	nust be complete	d in its entirety fo	r processing			
☐ Actemra (tocilizumab)	□Ac	temra (tocilizur	nab)	□Acte	mra (tocilizuma	.b)	
80mg/4ml IV injection	20	0mg/10ml IV in	jection	400n	400mg/20ml IV injection		
☐ Tyenne (tocilizumab-aa 80mg/4ml IV injection	Ç,	☐ Tyenne (tocilizumab-aazg) 200mg/10ml IV injection		☐ Tyenne (tocilizumab-aazg) 400mg/20ml IV injection			
**Check www.fepblue.org/formul			•	1001	g, 2 v 1 v je c		
 Has the patient been on the □NO – this is INITIAT! □YES – this is a PA rene 	ION of therapy, please	answer the ques	tions on PAGE 2			r below:	
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	s (TB) and hepatiti	s B virus (HE	BV)? □Yes □N	o	
5. Will the patient be given l	live vaccines while on	this therapy? 🗖	Yes □No				
6. Will this medication be us synthetic DMARD? □Y		h another biologi	c *disease-modify	ing antirheun	natic drug (DMA)	RD) or targ	eted
Olumiant, Orencia, Ot	v medication: mzelx, Cimzia, Cosentyx, ezla, Remicade, Renflexi , Tremfya, Truxima, Xelj	s, Riabni, Rinvoq,	Rituxan, Ruxience,				
7. What is the patient's diag	nosis?						
☐Giant cell arteritis							
a. Does the prescriber ag 4 weeks? □Yes □No		edication within	the FDA labeled ma	intenance dos	se of 6mg/kg every	ý.	
☐ Multicentric Castleman a. Does the prescriber		s medication with	in the maintenance	dose of 8mg	/kg every 2 week	xs? □Yes	□No
☐ Unicentric Castleman's	s disease						
a. Does the prescriber	agree to administer this	medication with	in the maintenance	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 &	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 Inform	ation (required)		Provider	r Informatio	n (required)
D	Pate:			Provider Name:		
P	atient Name:			Specialty:	NPI:	
D	Date of Birth:	Sex: ☐Male	□Female	Office Phone:	Office Fax:	
S	treet Address:			Office Street Address:	<u> </u>	
C	City:	State:	Zip:	City:	State:	Zip:
P	atient ID:			Physician Signature:		
	N	P	HYSICIAN C	OMPLETES		
	FOR C			GH THE PHARMACY BEN	EFIT:	
	For Standard and Basic Option pa are preferred products. Patien					
				is Injection		
	***Check			which medication is part of the p	patient'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	nswer 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				he 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	MARD) 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	d of corticostero	oids? □Yes □No
	b. Does the prescriber agree every week? □Yes □N		nedication within	the FDA labeled maintenan	ce dose of 162m	g
	□Rheumatoid Arthritis (RA)					
	a. Standard/Basic Option Humira or a Humira bios			through the pharmacy beaz/Xeljanz XR? □Yes □	nefit : Has the pa No*	atient tried and failed
	If NO, would you lik	te to switch the par	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	
	_		-	ventional DMARD?		
	*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)				
a. Standard/Basic Option patient, <u>f</u>				las the patient tried and faile	ed
Humira or Humira biosimilar, Enbi		•			
*If NO, would you like to switch		*			
*If YES, select the preferred	product: Humira/pr	referred biosimilar	□Enbrel	□Rinvoq/LQ □Xeljan	Z
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 □N	lo*	
*If NO, does the patient have an least one conventional DMARD?		ney had an inadequate	treatment respo	onse 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 medica	tion within the	FDA labeled maintenance of	lose
☐ Greater than or equal to 30kg maintenance dose of 162mg once			ister this medica	ation within the FDA labele	d
□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	e or leflunomide? \(\simeg\)Yes \(\simeg\)	No*
*If NO, has the patient experience					No
c. What is the patient's weight? <i>Please</i>	e select answer below:				
☐ Less than 30kg (66lbs): Does the of 162mg once every 2 weeks? □	ne prescriber agree to	administer this medicat	tion within the	FDA labeled maintenance of	lose
☐ Greater than or equal to 30kg maintenance dose of 162mg once			ister this medic	ation within the FDA labele	d
□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 a	dministration?	No
b. Does the prescriber agree to administ 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	Patient	miorma	ition (required)		Deoxy J N		nformation	(required)
Date:					Provider Nar	ne:		
Patient Nan	ne:				Specialty:		NPI:	
Date of Bir	h:		Sex: ☐Male	□Female	Office Phone	::	Office Fax:	
Street Address:				Office Street	Address:	•		
City:			State:	Zip:	City: State: Zip:		Zip:	
Patient ID:	R	Physician Signature:						
			I	PHYSICIAN (COMPLETE	CS		
	FOR CLAIMS ADJUDICATED THROUGH THE PHARMACY BENEFIT: For Standard and Basic Option patients Enbrel, Humira including preferred Humira biosimilars, Rinvoq, and Xeljanz/Xeljanz XR are preferred products. Patients who switch to a preferred product will be eligible for 2 copays at no cost in the benefit year.							
		CON	ITINUATIO	ON OF TH	ERAPY (PA RENEV	VAL)	
			S	ubcutaneo	us Injectio	on		
		**Check w	ww.fepblue.org/for	mulary to confirm	which medicatio	n is part of the patio	ent's benefit	
			NOTE: Form n	nust be complete	d in its entire	ty for processing		
□NO –	1. Has the patient been on this medication continuously for the last 6 months , <u>excluding samples</u> ? <i>Please select answer below:</i> □ NO – this is INITIATION of therapy, please answer the questions on <u>PAGE 6</u> □ YES – this is a PA renewal for CONTINUATION of therapy, please answer the questions below:					wer below:		
	quest for bran			Generic	, <u>r</u>	1		
	•	_	oved or stabilize	d with therapy?	□Yes □No)		
4. Does the	patient have	any active	infections inclu	ding tuberculosis	s (TB) and hep	oatitis B virus (H	BV)? □Yes □	■No
5. Will the	patient be giv	en live va	ccines while on t	this therapy?	Yes □No			
	medication be			n another biologi	c *disease-mo	odifying antirheu	matic drug (DM	MARD) or targeted
* <i>If YI</i>	ES, please spec	cify medic	cation:					
Olui	niant, Orencia,	Otezla, Re		s, Riabni, Rinvoq,	Rituxan, Ruxio	umira biosimilar, ence, Siliq, Simpo		a, Kevzara, Kineret, Skyrizi, Sotyktu,
7. What is	the patient's d	iagnosis?						
□Giant	cell arteritis							
	oes the prescri eek? □Yes [to administer this	medication with	in the FDA lab	eled maintenance	dose of 162mg	every
•		-	Arthritis (SJIA)					
	•		ght? <i>Please select</i>					
[□ Less than 30kg (66lbs): Does the prescriber agree to administer this medication within the FDA labeled maintenance dose of 162mg once every 2 weeks? □ Yes □ No							
I			al to 30kg (66lb) 162mg once ever			administer this	medication wit	hin the FDA labeled
□Syster	nic Sclerosis-	Associated	d Interstitial Lun	g Disease (SSc-l	LD)			
	oes the prescri		to administer this	medication with	in the FDA lab	eled maintenance	dose of 162mg	every

PLEASE PROCEED TO PAGE 9 FOR ADDITIONAL DIAGNOSES

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PAGE 9 - PHYSICIAN COMPLETES

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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 _			
☐ 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	vithin the F	DA labeled main	ntenance
-	al to 30kg (66lbs): Does the prescr 62mg every 2 weeks? \square Yes	_	nis medicat	ion within the Fl	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	lo		
*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 maintena	nce dose of	162mg every	
☐ Other diagnosis (please specify) :				

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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					
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							
Please select the diagnosis and	answer the following questions:						
☐ Rheumatoid arthritis (RA)						
a. Does the patient have an intolerance or contraindication* or have they had an inadequate treatment response to ONE of the following preferred medications: Humira or a Humira biosimilar, Enbrel, Rinvoq, or Xeljanz/Xeljanz XR?							
		tibody formation/lupus-like syndrome, or a histo ting disorder such as multiple sclerosis, Guillain					
Please select answer: \square	lYes □No*						
*If NO, is there a clinical	ll 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 resimilar, 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	lYes □No*						
*If NO, is there a clinical	d reason for not trying ONE of the	e preferred medications? □Yes □No					

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