BlueCross BlueShield
Federal Employee Program

TOCILIZUMAB
PRIOR APPROVAL REQUEST

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.

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

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:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

1. Is this medication being used to treat COVID-19? ❑Yes ❑No

   The FDA approved emergency use for Actemra or an Actemra biosimilar for the treatment of COVID-19 in hospitalized patients. This should be billed under the medical benefit.

2. **Will this medication be given by IV infusion or by subcutaneous (SC) injection?** ***Please select answer below:***

   ❑**IV infusion:** Has the patient been on this medication continuously for the last **6 months**, excluding samples?
   Please select answer below:
   - ❑**NO** – this is **INITIATION** of therapy, please answer the questions on **PAGES 2-3**
   - ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions on **PAGE 4-5**

   ❑**Subcutaneous injection**: Has the patient been on this medication continuously for the last **6 months**, excluding samples?
   Please select answer below:
   - ❑**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**

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

BlueCross BlueShield Federal Employee Program

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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:	State:	Zip:
Patient ID: R			Physician Signature:		

PHYSICIAN COMPLETES

IV injection

NOTE: Form must be completed in its **entirety** for processing

Please select medication:

❑**Actemra (tocilizumab) 80mg/4ml IV injection**	❑**Actemra (tocilizumab) 200mg/10ml IV injection**	❑**Actemra (tocilizumab) 400mg/20ml IV injection**
❑**Tyenne (tocilizumab-aazg) 80mg/4ml IV injection**	❑**Tyenne (tocilizumab-aazg) 200mg/10ml IV injection**	❑**Tyenne (tocilizumab-aazg) 400mg/20ml IV injection**

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

1. Has the patient been on this medication continuously for the last **6 months**, excluding samples? ***Please select answer below:***
   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions on **PAGE 4**
   ❑**NO –** this is **INITIATION** of therapy, please answer the questions below:
2. Is this request for brand or generic? ❑Brand ❑Generic
3. Has the patient had a recent test for a latent tuberculosis (TB)? ❑Yes* ❑ No
   If YES, was the result of the test positive or negative for TB infection? ❑Negative ❑Positive*
   If POSITIVE, has the patient completed treatment or is the patient currently receiving treatment for latent TB? ❑Yes ❑No
4. Is the patient at risk for hepatitis B virus (HBV) infection? ❑Yes* ❑No
   If YES, has HBV infection been ruled out or has the patient already started treatment for the HBV infection? ❑Yes ❑No
5. Does the patient have any active infections including tuberculosis (TB) and hepatitis B virus (HBV)? ❑Yes ❑No
6. Will the patient be given live vaccines while on this therapy? ❑Yes ❑No
7. Will this medication be used in combination with another biologic *disease-modifying antirheumatic drug (DMARD) or targeted synthetic DMARD? ❑Yes* ❑No
   If YES, please specify medication: _____
   DMARDs: Avsola, Bimzelx, Cimzia, Cosentyx, Enbrel, Entyvio, Humira or a Humira biosimilar, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Riabni, Rinvoq, Rituxan, Ruxience, Siliq, Simponi/Simponi Aria, Skyrizi, Sotyktu, Spevigo, Stelara, Taltz, Tremfya, Truxima, Xeljanz/Xeljanz XR, Zymfentra.
8. What is the patient's diagnosis?
   ❑Cytokine Release Syndrome (CRS)
   a. Does the patient have chimeric antigen receptor (CAR) T cell-induced CRS? ❑Yes ❑No
   b. Is the syndrome considered severe or life-threatening? ❑Yes ❑No
   c. Does the prescriber agree to only give this medication as an IV infusion and not by subcutaneous administration? ❑Yes ❑No
   d. What is the patient's weight? ***Please select answer below:***
   ❑**Less than 30kg (66lbs)**: Does the prescriber agree to administer this medication within the FDA labeled maintenance dose of 12mg/kg with up to 3 additional doses administered at least 8 hours apart? ❑Yes ❑No
   ❑**Greater than or equal to 30kg (66lbs)**: Does the prescriber agree to administer this medication within the FDA labeled maintenance dose of 8mg/kg with up to 3 additional doses administered at least 8 hours apart? ❑Yes ❑No

PLEASE PROCEED TO PAGE 3 FOR ADDITIONAL DIAGNOSES

BlueCross BlueShield Federal Employee Program

TOCILIZUMAB PRIOR APPROVAL REQUEST

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.

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PAGE 3 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

❑Giant cell arteritis
a. Has the patient experienced an inadequate treatment response to at least a 3 month trial of corticosteroids? ❑Yes ❑No
b. Does the prescriber agree to administer this medication within the FDA labeled maintenance dose of 6mg/kg every 4 weeks? ❑Yes ❑No

❑Multicentric Castleman's disease
a. Has the patient's disease progressed following treatment of relapsed/refractory or progressive disease? ❑Yes ❑No
b. Does the prescriber agree to only give this medication as an IV infusion and not by subcutaneous administration? ❑Yes ❑No
c. Is this medication being prescribed as a single agent therapy? ❑Yes ❑No
d. Does the prescriber agree to administer this medication within the maintenance dose of 8mg/kg every 2 weeks? ❑Yes ❑No

❑Unicentric Castleman's disease
a. Is the patient's disease relapsed or refractory? ❑Yes ❑No
b. Is the patient HIV negative? ❑Yes ❑No
c. Is the patient human herpesvirus-8 negative? ❑Yes ❑No
d. Is this medication being prescribed as a single agent therapy? ❑Yes ❑No
e. Does the prescriber agree to only give this medication as an IV infusion and not by subcutaneous administration? ❑Yes ❑No
f. Does the prescriber agree to administer this medication within the maintenance dose of 8mg/kg every 4 weeks? ❑Yes ❑No

❑Polyarticular Juvenile Idiopathic Arthritis (pJIA)
a. Is the patient's arthritis active? ❑Yes ❑No
b. Does the patient have a contraindication to at least one conventional DMARD? ❑Yes ❑No*
***If NO**, does the patient have an intolerance or have they had an inadequate treatment response to a 3 month trial of at least one conventional DMARD? ❑Yes ❑No
c. **For claims adjudicated through the pharmacy benefit**: Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a biologic DMARD or targeted synthetic DMARD? ❑Yes ❑No
d. What is the patient's weight? ***Please select answer below:***
❑**Less than 30kg (66lbs):** Does the prescriber agree to administer this medication within the FDA labeled maintenance dose of 10mg/kg every 4 weeks? ❑Yes ❑No
❑**Greater than or equal to 30kg (66lbs)**: Does the prescriber agree to administer this medication within the FDA labeled maintenance dose of 8mg/kg every 4 weeks? ❑Yes ❑No

❑Rheumatoid Arthritis (RA)
a. Does the patient have moderately to severely active rheumatoid arthritis? ❑Yes ❑No
b. Does the patient have a contraindication to at least one conventional DMARD? ❑Yes ❑No*
***If NO**, does the patient have an intolerance or have they had an inadequate treatment response to a 3 month trial of at least one conventional DMARD? ❑Yes ❑No
c. **For claims adjudicated through the pharmacy benefit**: Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a biologic DMARD or targeted synthetic DMARD? ❑Yes ❑No
d. Does the prescriber agree to administer this medication within the FDA labeled maintenance dose of 8mg/kg every 4 weeks? ❑Yes ❑No

❑Systemic Juvenile Idiopathic Arthritis (sJIA)
a. Is the patient's arthritis active? ❑Yes ❑No
b. Has the patient experienced an inadequate response to at least a 3 month trial of methotrexate or leflunomide? ❑Yes ❑No*
***If NO**, has the patient experienced an inadequate treatment response to at least a 2 week trial of corticosteroids? ❑Yes ❑No
c. What is the patient's weight? ***Please select answer below:***
❑**Less than 30kg (66lbs)**: Does the prescriber agree to administer this medication within the FDA labeled maintenance dose of 12mg/kg every 2 weeks? ❑Yes ❑No
❑**Greater than or equal to 30kg (66lbs):** Does the prescriber agree to administer this medication within the FDA labeled maintenance dose of 8mg/kg every 2 weeks? ❑Yes ❑No

❑Other diagnosis **(*please specify*):** _____

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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:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

CONTINUATION OF THERAPY (PA RENEWAL)
IV Injection

NOTE: Form must be completed in its **entirety** for processing

Please select medication:

❑**Actemra (tocilizumab) 80mg/4ml IV injection**	❑**Actemra (tocilizumab) 200mg/10ml IV injection**	❑**Actemra (tocilizumab) 400mg/20ml IV injection**
❑**Tyenne (tocilizumab-aazg) 80mg/4ml IV injection**	❑**Tyenne (tocilizumab-aazg) 200mg/10ml IV injection**	❑**Tyenne (tocilizumab-aazg) 400mg/20ml IV injection**

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

1. Has the patient been on this medication continuously for the last **6 months**, excluding samples? ***Please select answer below:***
   ❑**NO** – this is **INITIATION** of therapy, please answer the questions on **PAGE 2**
   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the question below:
2. Is this request for brand or generic? ❑Brand ❑Generic
3. Has the patient's condition improved or stabilized with therapy? ❑Yes ❑No
4. Does the patient have any active infections including tuberculosis (TB) and hepatitis B virus (HBV)? ❑Yes ❑No
5. Will the patient be given live vaccines while on this therapy? ❑Yes ❑No
6. Will this medication be used in combination with another biologic *disease-modifying antirheumatic drug (DMARD) or targeted synthetic DMARD? ❑Yes* ❑No
   If YES, please specify medication: _____
   DMARDs: Avsola, Bimzelx, Cimzia, Cosentyx, Enbrel, Entyvio, Humira or a Humira biosimilar, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Riabni, Rinvoq, Rituxan, Ruxience, Siliq, Simponi/Simponi Aria, Skyrizi, Sotyktu, Spevigo, Stelara, Taltz, Tremfya, Truxima, Xeljanz/Xeljanz XR, Zymfentra.
7. What is the patient's diagnosis?
   ❑Giant cell arteritis
   a. Does the prescriber agree to administer this medication within the FDA labeled maintenance dose of 6mg/kg every 4 weeks? ❑Yes ❑No
   ❑Multicentric Castleman's disease
   a. Does the prescriber agree to administer this medication within the maintenance dose of 8mg/kg every 2 weeks? ❑Yes ❑No
   ❑Unicentric Castleman's disease
   a. Does the prescriber agree to administer this medication within the maintenance dose of 8mg/kg every 4 weeks? ❑Yes ❑No
   ❑Polyarticular Juvenile Idiopathic Arthritis (PJIA)
   a. What is the patient's weight? ***Please select answer below:***
   ❑**Less than 30kg (66lbs):** Does the prescriber agree to administer this medication within the FDA labeled maintenance dose of 10mg/kg every 4 weeks? ❑Yes ❑No
   ❑**Greater than or equal to 30kg (66lbs)**: Does the prescriber agree to administer this medication within the FDA labeled maintenance dose of 8mg/kg every 4 weeks? ❑Yes ❑No

PLEASE PROCEED TO PAGE 5 FOR ADDITIONAL DIAGNOSES

BlueCross BlueShield Federal Employee Program

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PAGE 5 – PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

❑ Rheumatoid Arthritis (RA)

a. Does the prescriber agree to administer this medication within the FDA labeled maintenance dose of 8mg/kg every 4 weeks? ❑Yes ❑No

❑ Systemic Juvenile Idiopathic Arthritis (SJIA)

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

❑ **Less than 30kg (66lbs)**: Does the prescriber agree to administer this medication within the FDA labeled maintenance dose of 12mg/kg every 2 weeks? ❑Yes ❑No

❑ **Greater than or equal to 30kg (66lbs):** Does the prescriber agree to administer this medication within the FDA labeled maintenance dose of 8mg/kg every 2 weeks? ❑Yes ❑No

❑ Other diagnosis ***(please specify)***: _____

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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:	State:	Zip:
Patient ID: **R**			Physician Signature:		

PHYSICIAN COMPLETES

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.

Subcutaneous Injection

*****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

1. Has the patient been on this medication continuously for at least **6 months**, excluding samples? ***Please select answer below:***
   ❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions on **PAGE 8**
   ❑**NO –** this is **INITIATION** of therapy, please answer the questions below:
2. Is this request for brand or generic? ❑Brand ❑Generic
3. Has the patient been tested for latent tuberculosis (TB)? ❑Yes***** ❑ No
   ****If YES,*** was the result of the test positive or negative for TB infection? ❑Negative ❑Positive*****
   ****If POSITIVE***, has the patient completed treatment or is the patient currently receiving treatment for latent TB? ❑Yes ❑No
4. Is the patient at risk for hepatitis B virus (HBV) infection? ❑Yes***** ❑No
   ****If YES,*** has HBV infection been ruled out or has the patient already started treatment for the HBV infection? ❑Yes ❑No
5. Does the patient have any active infections including tuberculosis (TB) and hepatitis B virus (HBV)? ❑Yes ❑No
6. Will the patient be given live vaccines while on this therapy? ❑Yes ❑No
7. Will this medication be used in combination with another biologic *****disease-modifying antirheumatic drug **(**DMARD) or targeted synthetic DMARD? ❑Yes***** ❑No
   ****If YES***, please specify medication: _____
   ****DMARDs: Avsola, Bimzelx, Cimzia, Cosentyx, Enbrel, Entyvio, Humira or a Humira biosimilar, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Riabni, Rinvoq, Rituxan, Ruxience, Siliq, Simponi/Simponi Aria, Skyrizi, Sotyktu, Spevigo, Stelara, Taltz, Tremfya, Truxima, Xeljanz/Xeljanz XR, Zymfentra.***
8. What is the patient's diagnosis?
   ❑Giant cell arteritis
   a. Has the patient experienced an inadequate treatment response to at least a 3 month trial of corticosteroids? ❑Yes ❑No
   b. Does the prescriber agree to administer this medication within the FDA labeled maintenance dose of 162mg every week? ❑Yes ❑No
   ❑Rheumatoid Arthritis (RA)
   a. **Standard/Basic Option patient, for claims adjudicated through the pharmacy benefit**: Has the patient tried and failed Humira or a Humira biosimilar, Enbrel, Rinvoq, or Xeljanz/Xeljanz XR? ❑Yes ❑No*****
      ****If NO***, would you like to switch the patient to a preferred product? ❑Yes***** ❑No
      ****If YES***, select the preferred product: ❑Humira/preferred biosimilar ❑Enbrel ❑Rinvoq ❑Xeljanz/Xeljanz XR
   b. Does the patient have moderately to severely active rheumatoid arthritis? ❑Yes ❑No
   c. Does the patient have a contraindication to at least one conventional DMARD? ❑Yes ❑No*****
      ****If NO***, does the patient have an intolerance or have they had an inadequate treatment response to a 3 month trial of at least one conventional DMARD? ❑Yes ❑No
   d. Does the prescriber agree to administer this medication within the FDA labeled maintenance dose of 162mg every week? ❑Yes ❑No

PLEASE PROCEED TO PAGE 6 FOR ADDITIONAL DIAGNOSES

BlueCross BlueShield Federal Employee Program

TOCILIZUMAB PRIOR APPROVAL REQUEST

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PAGE 7 – PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

❑Polyarticular Juvenile Idiopathic Arthritis (pJIA)

a. **Standard/Basic Option patient, <u>for claims adjudicated through the pharmacy benefit</u>**: Has the patient tried and failed Humira or Humira biosimilar, Enbrel, Rinvoq/LQ, or Xeljanz? ❑Yes ❑No*

If NO, would you like to switch the patient to a preferred product? ❑Yes* ❑No

If YES, select the preferred product: ❑Humira/preferred biosimilar ❑Enbrel ❑Rinvoq/LQ ❑Xeljanz

b. Is the patient's arthritis active? ❑Yes ❑No

c. Does the patient have a contraindication to at least one conventional DMARD? ❑Yes ❑No*

If NO, does the patient have an intolerance or have they had an inadequate treatment response to a 3 month trial of at least one conventional DMARD? ❑Yes ❑No

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

❑ **Less than 30kg (66lbs):** Does the prescriber agree to administer this medication within the FDA labeled maintenance dose of 162mg once every 3 weeks? ❑Yes ❑No

❑ **Greater than or equal to 30kg (66lbs)**: Does the prescriber agree to administer this medication within the FDA labeled maintenance dose of 162mg once every 2 weeks? ❑Yes ❑No

❑Systemic Juvenile Idiopathic Arthritis (sJIA)

a. Is the patient's arthritis active? ❑Yes ❑No

b. Has the patient experienced an inadequate response to at least a 3 month trial of methotrexate or leflunomide? ❑Yes ❑No*

If NO, has the patient experienced an inadequate treatment response to at least a 2 week trial of corticosteroids? ❑Yes ❑No

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

❑ **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

❑ **Greater than or equal to 30kg (66lbs):** Does the prescriber agree to administer this medication within the FDA labeled maintenance dose of 162mg once every week? ❑Yes ❑No

❑Systemic Sclerosis-Associated Interstitial Lung Disease (SSc-ILD)

a. Does the prescriber agree to only give this medication as a subcutaneous dose and not by IV administration? ❑Yes ❑No

b. Does the prescriber agree to administer this medication within the FDA labeled maintenance dose of 162mg every week? ❑Yes ❑No

❑ Other diagnosis **(*please specify*):** _____

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

BlueCross BlueShield Federal Employee Program

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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:	State:	Zip:
Patient ID: R			Physician Signature:		

PHYSICIAN COMPLETES

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.

CONTINUATION OF THERAPY (PA RENEWAL)
Subcutaneous Injection

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

1. Has the patient been on this medication continuously for the last **6 months**, excluding samples? ***Please select answer below:***
   ❑ **NO** – this is **INITIATION** of therapy, please answer the questions on **PAGE 6**
   ❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions below:
2. Is this request for brand or generic? ❑Brand ❑Generic
3. Has the patient's condition improved or stabilized with therapy? ❑Yes ❑No
4. Does the patient have any active infections including tuberculosis (TB) and hepatitis B virus (HBV)? ❑Yes ❑No
5. Will the patient be given live vaccines while on this therapy? ❑Yes ❑No
6. Will this medication be used in combination with another biologic *disease-modifying antirheumatic drug (DMARD) or targeted synthetic DMARD? ❑Yes* ❑No
   If YES, please specify medication: _____
   DMARDs: Avsola, Bimzelx, Cimzia, Cosentyx, Enbrel, Entyvio, Humira or a Humira biosimilar, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Riabni, Rinvoq, Rituxan, Ruxience, Siliq, Simponi/Simponi Aria, Skyrizi, Sotyktu, Spevigo, Stelara, Taltz, Tremfya, Truxima, Xeljanz/Xeljanz XR, Zymfentra.
7. What is the patient's diagnosis?
   ❑Giant cell arteritis
      a. Does the prescriber agree to administer this medication within the FDA labeled maintenance dose of 162mg every week? ❑Yes ❑No
   ❑ Systemic Juvenile Idiopathic Arthritis (SJIA)
      a. What is the patient's weight? ***Please select answer below:***
         ❑ **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
         ❑ **Greater than or equal to 30kg (66lbs):** Does the prescriber agree to administer this medication within the FDA labeled maintenance dose of 162mg once every week? ❑Yes ❑No
   ❑Systemic Sclerosis-Associated Interstitial Lung Disease (SSc-ILD)
      a. Does the prescriber agree to administer this medication within the FDA labeled maintenance dose of 162mg every week? ❑Yes ❑No

PLEASE PROCEED TO PAGE 9 FOR ADDITIONAL DIAGNOSES

BlueCross BlueShield Federal Employee Program

TOCILIZUMAB
PRIOR APPROVAL REQUEST

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.

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Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

PAGE 9 - PHYSICIAN COMPLETES

Patient Name: _____ DOB: _____ Patient ID: R _____

❑ Polyarticular Juvenile Idiopathic Arthritis (PJIA)

a. **Standard/Basic Option patient, <u>for claims adjudicated through the pharmacy benefit</u>**: Has the patient tried and failed Humira or a Humira biosimilar, Enbrel, Rinvoq/LQ, or Xeljanz? ❑Yes ❑No*****

If NO, would you like to switch the patient to a preferred product? ❑Yes***** ❑No

If YES, please select the preferred product: ❑Humira/preferred biosimilar ❑Enbrel ❑Rinvoq/LQ ❑Xeljanz

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

❑ **Less than 30kg (66lbs):** Does the prescriber agree to administer this medication within the FDA labeled maintenance dose of 162mg once every 3 weeks? ❑Yes ❑No

❑ **Greater than or equal to 30kg (66lbs)**: Does the prescriber agree to administer this medication within the FDA labeled maintenance dose of 162mg every 2 weeks? ❑Yes ❑No

❑ Rheumatoid Arthritis (RA)

a. **Standard/Basic Option patient, <u>for claims adjudicated through the pharmacy benefit</u>**: Has the patient tried and failed Humira or a Humira biosimilar, Enbrel, Rinvoq, or Xeljanz/Xeljanz XR? ❑Yes ❑No*****

If NO, would you like to switch the patient to a preferred product? ❑Yes***** ❑No

If YES, select the preferred product: ❑Humira/preferred biosimilar ❑Enbrel ❑Rinvoq ❑Xeljanz/Xeljanz XR

b. Does the prescriber agree to administer this medication within the FDA labeled maintenance dose of 162mg every week? ❑Yes ❑No

❑ Other diagnosis **(*please specify*):** _____

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

BlueCross BlueShield Federal Employee Program

TOCILIZUMAB
PRIOR APPROVAL REQUEST

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.

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

PAGE 10 - PHYSICIAN COMPLETES

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

1. 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?

Contraindications include (not all inclusive): allergy, autoantibody formation/lupus-like syndrome, or a history of congestive heart failure, hepatitis B virus infection, malignancy, or demyelinating disorder such as multiple sclerosis, Guillain-Barre syndrome, or optic neuritis.

Please select answer: ❑Yes ❑No*

***If NO,** is there a clinical reason for not trying **ONE** of the preferred medications? ❑Yes ❑No

❑**Polyarticular juvenile idiopathic arthritis (pJIA)**

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/LQ, or Xeljanz?

Contraindications include (not all inclusive): allergy, autoantibody formation/lupus-like syndrome, or a history of congestive heart failure, hepatitis B virus infection, malignancy, or demyelinating disorder such as multiple sclerosis, Guillain-Barre syndrome, or optic neuritis.

Please select answer: ❑Yes ❑No*

***If NO,** is there a clinical reason for not trying **ONE** of the preferred medications? ❑Yes ❑No