

### **MEDICARE FORM**

# Actemra® (tocilizumab) Injectable Medication Precertification Request

Page 1 of 3

(All fields must be completed and legible for precertification review.)

FAX: 1-855-320-8445 PHONE: 1-866-600-2139

For other lines of business: Please use other form.

Note: Actemra is non-preferred. Preferred products may vary based on indication. See section G below.

| Please indicate:  |           |            |                          |   | //<br>t treatment/                | /           |           |          | on man | auon. | . Jee section | i G below. |
|---|-----------|------------|--------------------------|---|-----------------------------------|-------------|-----------|----------|--------|-------|---------------|------------|
| Precertification F  |           |            |                          |   |                                   | Phone:      |           |          | Fa     | ax:   |               |            |
| A. PATIENT INFO   | ORMATION  |            |                          |   |                                   |             |           |          |        |       |               |            |
| First Name:   |           |            |                          |   | Last Name:                        |             |           |          | DOB:   |       |               |            |
| Address:  |           |            |                          |   |                                   | City:       |           |          | State: |       | ZIP:          |            |
| Home Phone:   |           |            | Work Pho                 | ne:   |                                   | Cell Phone: |           |          | Email: |       |               |            |
| Current Weight:   | lbs       | or         | kgs F                    | leight  | :inches or                        | cms         | Allergie  | es:      | II.    |       |               |            |
| B. INSURANCE I  | NFORMATI  | ON         |                          |   |                                   |             | _         |          |        |       |               |            |
| Aetna Member ID #: Does patient have other coverage?  |           |            |                          |   |                                   |             |           |          |        |       |               |            |
| Group #:  |           |            |                          |   | If yes, provide ID#:Carrier Name: |             |           |          |        |       |               |            |
| Insured:  |           |            |                          |   | Insured:                          |             |           |          |        |       |               |            |
| C. PRESCRIBER   | INFORMAT  | ΓΙΟΝ       |                          |   |                                   |             |           |          |        |       |               |            |
| First Name:   |           |            |                          |   | Last Name:                        |             | (Che      | ck One): |        | □ D.  | O. N.P.       | . 🗌 P.A.   |
| Address:  |           |            |                          |   |                                   | City:       |           |          | State: |       | ZIP:          |            |
| Phone:  |           | Fax:       |                          |   | St Lic #:                         | NPI #:      |           | DEA #:   |        | U     | JPIN:         |            |
| Provider Email:   |           |            |                          | Offic   | ce Contact Name:                  |             |           | Phone:   |        |       |               |            |
| D. DISPENSING   | PROVIDER/ | ADMINIST   | RATION I                 | NFOR  | RMATION                           | _           |           |          |        |       |               |            |
| Place of Administration:  Self-administered Physician's Office Outpatient Infusion Center Center Name: Home Infusion Center Agency Name: Administration code(s) (CPT): Address: City: State: Phone: Fax: TIN: NPI: Please explain if there are any medical reason(s) why the inject the requested drug:   |           |            | P:e patient cannot self- | Dispensing Provider/Pharmacy:  Physician's Office Retail Pharmacy  Specialty Pharmacy Mail Order  Other:  Name:  Address:  City: State: ZIP:  Phone: Fax:  TIN: PIN:  NPI:  E. PRODUCT INFORMATION  Request is for: Actemra (tocilizumab) IV  Actemra (tocilizumab) SC  HCPCS Code: Dose:  Frequency: |                                   |             |           |          |        |       |               |            |
|   |           | N - Please | indicate p               | rimar   | y ICD code and specify            |             | applicabl | e (*).   |        |       |               |            |
| Primary ICD Cod   | <u>.</u>  |            |                          |   |                                   | r ICD Code: |           |          |        |       |               |            |
| G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.  For Initiation requests (clinical documentation required):  Yes No Will Actemra (tocilizumab) be used concomitantly with apremilast, tofacitinib, or other biologic DMARDs (e.g., adalimumab, infliximab)?  Has the patient been tested for TB with a PPD test, interferon-release assay (IGRA) or chest x-ray within 6 months of initiating a biologic therapy?  (check all that apply): PPD test interferon-gamma assay (IGRA) chest x-ray  Please enter results of the TB test results: Positive Negative Unknown  If positive, Does the patient have latent or active TB? Latent Active  If latent TB, Yes No Will TB treatment be started before initiation of therapy with Actemra (tocilizumab)? |           |            |                          |   |                                   |             |           |          |        |       |               |            |
| Note: Actemra is non-preferred. Inflectra, Remicade, and Simponi Aria are preferred for MA plans. Enbrel, Humira, Kevzara, Rinvoq, and Xeljanz/Xeljanz XR are preferred for MAPD plans. Preferred products may vary based on indication.  Yes No Has the patient had prior therapy with Actemra (tocilizumab) within the last 365 days? Has the patient had a trial and failure, intolerance, or contraindication to any of the following? (select all that apply) Inflectra (infliximab-dyyb) Remicade (infliximab) Simponi Aria (golimumab) Has the patient had a trial and failure, intolerance, or contraindication to any of the following? (select all that apply) Enbrel (etanercept) Humira (adalimumab) Kevzara (sarilumab) Rinvoq (upadacitinib) Xeljanz/Xeljanz XR (tofacitinib)   |           |            |                          |   |                                   |             |           |          |        |       |               |            |



#### **MEDICARE FORM**

## Actemra® (tocilizumab) Injectable Medication Precertification Request

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(All fields must be completed and legible for precertification review.)

For Illinois MMP:

**FAX:** 1-855-320-8445 **PHONE:** 1-866-600-2139

For other lines of business: Please use other form.

Note: Actemra is non-preferred. Preferred products may vary based on indication. See section G.

| CLINICAL INFORMATION (continued)   Required clinical information must be completed in its gatinary (or all precentification requests.   Please explain if there are any other medical reason(s) that the patient cannot use any of the following preferred products when indicated for the patient's diagnosis (select all that apply)   Remicade (infliximab)   Simponi Aria (golimumab)  | Patient First Name                              | Patient Last Name                              | Patient Phone                | Patient DOB                            |  |  |  |  |
|--|---|--|------------------------------|--|--|--|--|--|
| Please explain if there are any other medical reason(s) that the patient cannot use any of the following preferred products when indicated for the patient's diagnosis (select all that apply)   Remicade (infliximab)   Simponi Aria (golimumab)  | G. CLINICAL INFORMATION (continued)             | - Required clinical information must be co     | empleted in its entirety for | all precertification requests.         |  |  |  |  |
| Inflectra (infliximab-dyyb)   Remicade (infliximab)   Simponi Aria (golimumab)   |   |  |                              |  |  |  |  |  |
| Please explain if there are any other medical reason(s) that the patient cannot use any of the following preferred products when indicated for the patient's diagnosis (select all that apply)    Castleman's disease (CD)   Yes   No   Is this request for IV formulation?   Yes   No   Will Actemate (tocilizumabl) be used as a monotherapy?   Yes   No   Does the patient have unicentric CD?   Yes   No   No   See the patient have unicentric CD?   Yes   No   No   Is the patient have unicentric CD?   Yes   No   No   Is the patient human immunodeficiency virus (HIV) negative?   Yes   No   No   Is the patient human immunodeficiency virus (HIV) negative?   Yes   No   No   Is the patient human human herpesvirus (HIV) negative?   Yes   No   No   Is the patient human human herpesvirus (HIV) negative?   Yes   No   No   Is the patient human human herpesvirus (HIV) negative?   Yes   No   No   Is the patient human human herpesvirus (HIV) negative?   Yes   No   No   Is the patient have documented multicentric CD?   Yes   No   Is this request for IV formulation?   Yes   No   Is the patient have a documented diagnosis of chimeric antigen receptor (CAR) T cell-induced severe or life threatening cytokine release syndrome?   Yes   No   Is the request for IV formulation   Iv formulation   Iv formulation rate [ESR])?   Yes   No   Does the patient have high serum C-reactive protein (Re)?   Yes   No   Does the patient have high serum C-reactive protein (Re)?   Yes   No   Does the patient have high serum C-reactive protein (Re)?   Yes   No   No   Iv formulation   Iv formula |   |  |                              |  |  |  |  |  |
| Castleman's disease (CD)   | │   | ☐ Remicade (infliximab) ☐ Simponi Aria         | (golimumab)                  |  |  |  |  |  |
| Castleman's disease (CD)   |   |  |                              |  |  |  |  |  |
| Castleman's disease (CD)   | Please explain if there are any other medical   | reason(s) that the patient cannot use any of   | the following preferred prod | ducts when indicated for the patient's |  |  |  |  |
| Castleman's disease (CD)   | 1 3,  | _  | _                            | _                                      |  |  |  |  |
| Yes   No   Is this request for IV formulation?   Yes   No   No   Will Actemra (tocilizumab) be used as a monotherapy?   No   No   No   No   No   No   No   N   | ☐ Enbrel (etanercept) ☐ F                       | -lumira (adalimumab) ⊔ Kevzara (sariluma       | b)   ∐ Rinvoq (upadacitinib  |  |  |  |  |  |
| Yes   No   Is this request for IV formulation?   Yes   No   No   Will Actemra (tocilizumab) be used as a monotherapy?   No   No   No   No   No   No   No   N   |   |  |                              |  |  |  |  |  |
| Yes   No   No   Will Acterna (tocilizumab) be used as a monotherapy?   Does the patient have unicentric CD?   Please identify if the patient has relapsed or refractory CD:   Relapsed   Refractory   Please identify if the patient has relapsed or refractory CD:   Relapsed   Refractory   Please identify if the patient human immunodeficiency virus (HIV) negative?   Yes   No   Is the patient human immunodeficiency virus (HIV) negative?   Please identify if the patient human herpesvirus-8 (HHV-8) negative?   Does the patient have documented multicentric CD?   Yes   No   Will Acterna (tocilizumab) be used as subsequent therapy?   Has the disease progressed following treatment of relapsed/refractory or progressive disease?   Verballow   No   St this request for IV formulation?   St this request for IV formulation?   St this request for IV formulation?   St this request for subcutaneous formulation?   Please select which one:   temporal artery biopsy or cross-sectional imaging?   Please select which one:   temporal artery biopsy   Cross-sectional imaging   Please select which one:   temporal artery biopsy   Cross-sectional imaging   Please select which one:   temporal artery biopsy   Cross-sectional imaging   Please select which one:   temporal artery biopsy   Cross-sectional imaging   Please select which one:   temporal artery biopsy   Cross-sectional imaging   Please select which one:   temporal artery biopsy   Cross-sectional imaging   Please select which one:   temporal artery biopsy   Cross-sectional imaging   Please select which one:   temporal artery biopsy   Cross-sectional imaging   Please select which one:   temporal artery biopsy   Cross-sectional imaging   Please select which one:   temporal artery biopsy   Cross-sectional imaging   Please select which one:   temporal artery biopsy   Cross-sectional imaging   Please select which one:   temporal artery biopsy   Cross-sectional imaging   Please select which one:   temporal artery biopsy   Cross-sectional imaging   Please select which one:   temporal artery b   | Castleman's disease (CD)                        |  |                              |  |  |  |  |  |
| Yes   No   Does the patient have unicentric CD?  | ☐ Yes ☐ No Is this request for IV formul        | ation?   |                              |  |  |  |  |  |
| Please identify if the patient has relapsed or refractory CD:   Relapsed   Refractory   Yes   No   Will Actemra (locilizumab) be used a second-line therapy?   Yes   No   Is the patient human herpesvirus-8 (HHV-8) negative?   Yes   No   Does the patient have documented multicentric CD?   Yes   No   Has the disease progressed following treatment of relapsed/refractory or progressive disease?   Yes   No   Is this request for IV formulation?   Yes   No   Is this request for subcutaneous formulation?   Yes   No   Is this request for subcutaneous formulation?   Yes   No   Yes   No   Is the patient have a documented diagnosis of chimeric antigen receptor (CAR) T cell-induced severe or life threatening cytokine release syndrome?   Yes   No   Is this request for subcutaneous formulation?   Yes   No   Yes   No   Yes   No   Yes   No   Yes   No   Yes   Ye |   |  |                              |  |  |  |  |  |
| Yes   No   | 1 1   |  |                              |  |  |  |  |  |
| Yes   No   |   |  | -                            |  |  |  |  |  |
| Yes   No   No   No   No   No   No   No   N   |   |  |                              |  |  |  |  |  |
| Yes  |   |  | -                            |  |  |  |  |  |
| Cytokine release syndrome         Is this request for IV formulation?           Yes  |   |  |                              |  |  |  |  |  |
| Cytokine release syndrome    Yes   No  | Yes No Will Acter                               | nra (tocilizumab) be used as subsequent the    | rapy?                        |  |  |  |  |  |
| Yes   No   Does the patient have a documented diagnosis of chimeric antigen receptor (CAR) T cell-induced severe or life threatening cytokine release syndrome?    Giant cell arteritis   Yes   No   Is this request for subcutaneous formulation?   Yes   No   Has the patient had a temporal artery biopsy or cross-sectional imaging?   Yes   No   Does the patient have acute-phase reactant elevation (i.e., high erythrocyte sedimentation rate [ESR])?   Yes   No   Does the patient have high serum C-reactive protein [CRP]?   Juvenile idiopathic arthritis (juvenile rheumatoid arthritis)   Is this request for IV formulation or subcutaneous formulation?   IV formulation   subcutaneous formulation   What is the severity of the patient's disease?   Mild   Moderate   Severe   Yes   No   Is there evidence that the disease is active?   Rheumatoid Arthritis   Is this request for IV formulation or subcutaneous formulation?   IV formulation   subcutaneous formulation   Please indicate the severity of the patient's rheumatoid arthritis:   Mild   Moderate   Severe   Yes   No   Is there evidence that the disease is active?   Yes   No   Was treatment with methotrexate ineffective?   Yes   No   Was treatment with methotrexate not tolerated   contraindicated   Yes   No   Was treatment with methotrexate ineffective?   Yes   No   No   Was treatment with methotrexate not tolerated   contraindicated   Yes   No   No   Was treatment with another conventional DMARD (other than methotrexate) ineffective?  | ☐ Yes ☐ No Has the disease progressed           | d following treatment of relapsed/refractory o | r progressive disease?       |  |  |  |  |  |
| Yes   No   Does the patient have a documented diagnosis of chimeric antigen receptor (CAR) T cell-induced severe or life threatening cytokine release syndrome?    Giant cell arteritis   Yes   No   Is this request for subcutaneous formulation?   Yes   No   Is this request for subcutaneous formulation?   Yes   No   Has the patient had a temporal artery biopsy   cross-sectional imaging?   Yes   No   Does the patient have acute-phase reactant elevation (i.e., high erythrocyte sedimentation rate [ESR])?   Yes   No   Does the patient have high serum C-reactive protein [CRP]?   Is this request for IV formulation or subcutaneous formulation?   IV formulation   subcutaneous formulation   Street   Yes   No   Is there evidence that the disease is active?   Rheumatoid Arthritis   Is this request for IV formulation or subcutaneous formulation?   IV formulation   subcutaneous formulation   Please indicate the severity of the patient's rheumatoid arthritis:   Mild   Moderate   Severe   Yes   No   Is there evidence that the disease is active?   Yes   No   Was treatment with methotrexate ineffective?   Yes   No   Was treatment with methotrexate not tolerated   contraindicated?   Yes   No   Was treatment with methotrexate not tolerated   Contraindicated   Yes   No   Was treatment with another conventional DMARD (other than methotrexate) ineffective?  |   |  |                              |  |  |  |  |  |
| release syndrome?  Giant cell arteritis  Yes   | l = - ·   |  |                              |  |  |  |  |  |
| Giant cell arteritis    Yes   No   |   | cumented diagnosis of chimeric antigen rece    | ptor (CAR) i cell-induced s  | severe or life inreatening cytokine    |  |  |  |  |
| Yes  | ·   |  |                              |  |  |  |  |  |
| Please select which one:temporal artery biopsycross-sectional imagingYesNoDoes the patient have acute-phase reactant elevation (i.e., high erythrocyte sedimentation rate [ESR])?YesNoDoes the patient have high serum C-reactive protein [CRP]?   |   | eous formulation?                              |                              |  |  |  |  |  |
| Yes  | ☐ Yes ☐ No Has the patient had a temp           | oral artery biopsy or cross-sectional imaging  | ?                            |  |  |  |  |  |
| □ Yes       No       Does the patient have high serum C-reactive protein [CRP]?         Juvenile idiopathic arthritis (juvenile rheumatoid arthritis)         Is this request for IV formulation or subcutaneous formulation? □ IV formulation □ subcutaneous formulation         What is the severity of the patient's disease? □ Mild □ Moderate □ Severe       □ Yes □ No Is there evidence that the disease is active?         Rheumatoid Arthritis         Is this request for IV formulation or subcutaneous formulation? □ IV formulation □ subcutaneous formulation         Please indicate the severity of the patient's rheumatoid arthritis: □ Mild □ Moderate □ Severe         □ Yes       No       Is there evidence that the disease is active?         □ Yes       No       Was treatment with methotrexate ineffective?         □ Yes       No       Was treatment with methotrexate not tolerated or contraindicated?         □ Please select: □ not tolerated □ contraindicated       □ contraindicated         □ Yes       No       Was treatment with another conventional DMARD (other than methotrexate) ineffective?  |   |  |                              |  |  |  |  |  |
| Juvenile idiopathic arthritis (juvenile rheumatoid arthritis)  Is this request for IV formulation or subcutaneous formulation?   |   |  | cyte sedimentation rate [ES  | R])?                                   |  |  |  |  |
| Is this request for IV formulation or subcutaneous formulation? IV formulation subcutaneous formulation  What is the severity of the patient's disease? Mild Moderate Severe  Yes No Is there evidence that the disease is active?  Rheumatoid Arthritis  Is this request for IV formulation or subcutaneous formulation? IV formulation subcutaneous formulation  Please indicate the severity of the patient's rheumatoid arthritis: Mild Moderate Severe  Yes No Is there evidence that the disease is active?  Yes No Was treatment with methotrexate ineffective?  Please select: not tolerated contraindicated  Yes No Was treatment with another conventional DMARD (other than methotrexate) ineffective?  |   |  |                              |  |  |  |  |  |
| What is the severity of the patient's disease?   | ,   |  |                              |  |  |  |  |  |
| ☐ Yes       No       Is there evidence that the disease is active?         Rheumatoid Arthritis         Is this request for IV formulation or subcutaneous formulation? ☐ IV formulation ☐ subcutaneous formulation         Please indicate the severity of the patient's rheumatoid arthritis: ☐ Mild ☐ Moderate ☐ Severe         ☐ Yes       No       Is there evidence that the disease is active?         ☐ Yes       No       Was treatment with methotrexate ineffective?         ☐ Yes       No       Was treatment with methotrexate not tolerated or contraindicated?         ☐ Please select: ☐ not tolerated ☐ contraindicated         ☐ Yes       No       Was treatment with another conventional DMARD (other than methotrexate) ineffective?  | · · · · · · · · · · · · · · · · · · ·           |  |                              |  |  |  |  |  |
| Is this request for IV formulation or subcutaneous formulation?     IV formulation   |   |  |                              |  |  |  |  |  |
| Please indicate the severity of the patient's rheumatoid arthritis:  Mild  Moderate  Severe  Yes  No  Is there evidence that the disease is active?  Yes  No  Was treatment with methotrexate ineffective?  Yes  No  Was treatment with methotrexate not tolerated or contraindicated?  Please select:  not tolerated  contraindicated  Yes  No  Was treatment with another conventional DMARD (other than methotrexate) ineffective?  | Rheumatoid Arthritis                            |  |                              |  |  |  |  |  |
| ☐ Yes ☐ No Is there evidence that the disease is active? ☐ Yes ☐ No Was treatment with methotrexate ineffective? ☐ Yes ☐ No Was treatment with methotrexate not tolerated or contraindicated? ☐ Yes ☐ No Was treatment with another conventional DMARD (other than methotrexate) ineffective?  | Is this request for IV formulation or subcutane | eous formulation?  IV formulation  subo        | cutaneous formulation        |  |  |  |  |  |
| ☐ Yes ☐ No Was treatment with methotrexate ineffective?  ☐ Yes ☐ No Was treatment with methotrexate not tolerated or contraindicated?  ☐ Please select: ☐ not tolerated ☐ contraindicated  ☐ Yes ☐ No Was treatment with another conventional DMARD (other than methotrexate) ineffective?   |   |  | Severe                       |  |  |  |  |  |
| Yes No Was treatment with methotrexate not tolerated or contraindicated?  Please select: not tolerated contraindicated  Yes No Was treatment with another conventional DMARD (other than methotrexate) ineffective?  |   |  |                              |  |  |  |  |  |
| Please select: ☐ not tolerated ☐ contraindicated ☐ Tyes ☐ No Was treatment with another conventional DMARD (other than methotrexate) ineffective?  |   |  | aindicated?                  |  |  |  |  |  |
| ☐ Yes ☐ No Was treatment with another conventional DMARD (other than methotrexate) ineffective?  |   |  | amuicated?                   |  |  |  |  |  |
|  |   |  | ional DMARD (other than m    | nethotrexate) ineffective?             |  |  |  |  |
| Provide select. 🗀 azatnioprine 🗀 nydroxychioroddine 🗀 leilunomide 🗀 suliasalazine  |   |  |                              |  |  |  |  |  |
| Systemic juvenile idiopathic arthritis   |   |  |                              |  |  |  |  |  |
| Is this request for IV formulation or subcutaneous formulation?   IV formulation  subcutaneous formulation   |   |  |                              |  |  |  |  |  |
| Yes No Is there evidence that the disease is active?   |   |  |                              |  |  |  |  |  |
| Yes No Does the patient's initial symptoms include high fevers and painful polyarthritis?  | I   | -  |                              |  |  |  |  |  |
| ☐ Yes ☐ No Was treatment with non-steroidal anti-inflammatory (NSAID) monotherapy ineffective?  → Provide the name of the NSAID:   |   |  | py menective?                |  |  |  |  |  |

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### **MEDICARE FORM**

## Actemra® (tocilizumab) Injectable Medication Precertification Request

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(All fields must be completed and legible for precertification review.)

For Illinois MMP:

**FAX:** 1-855-320-8445 **PHONE:** 1-866-600-2139

For other lines of business:

Please use other form.

Note: Actemra is non-preferred. Preferred products may vary based on indication. See section G.

| Patient Last Name   | Patient Phone   | Patient DOB   |  |  |  |  |  |
|---|---|---|--|--|--|--|--|
| G. CLINICAL INFORMATION (continued) - Required clinical information must be completed in its entirety for all precertification requests.  |   |   |  |  |  |  |  |
| For ALL continuation of therapy requests (clinical documentation required for all requests):  |   |   |  |  |  |  |  |
| ☐ Yes ☐ No Is this continuation request a result of the patient receiving samples of Actemra (tocilizumab)?   |   |   |  |  |  |  |  |
| Yes No Will Actemra (tocilizumab) be used concomitantly with apremilast, tofacitinib, or other biologic DMARDs (e.g., adalimumab, infliximab)?  |   |   |  |  |  |  |  |
| Yes No Is there clinical documentation supporting disease stability?  |   |   |  |  |  |  |  |
| Yes No Is there clinical documentation supporting disease improvement?  |   |   |  |  |  |  |  |
| Yes No Does the patient have any risk factors for TB?   |   |   |  |  |  |  |  |
| Yes No Has the patient had a TB test within the past year?  |   |   |  |  |  |  |  |
|   |   |   |  |  |  |  |  |
|   |   |   |  |  |  |  |  |
| For IV formulation requests only (continuation of therapy requests only):  Yes No Has the patient received Actemra (tocilizumab) within the past 6 months?  |   |   |  |  |  |  |  |
| Yes No Does the patient have a documented severe and/or potentially life-threatening adverse event that occurred during or following  |   |   |  |  |  |  |  |
| the previous infusion?  |   |   |  |  |  |  |  |
| Yes No Could the adverse reaction be managed through pre-medication in the home or office setting?  |   |   |  |  |  |  |  |
| For juvenile idiopathic arthritis (juvenile rheumatoid arthritis), rheumatoid arthritis or systemic juvenile idiopathic arthritis only:   |   |   |  |  |  |  |  |
| Please indicate the severity of the patient's arthritis at baseline (pretreatment with Actemra (tocilizumab)):   Mild  Moderate  Severe   |   |   |  |  |  |  |  |
| H. ACKNOWLEDGEMENT  |   |   |  |  |  |  |  |
| irod).  |   | Date: / /   |  |  |  |  |  |
| Request Completed By (Signature Required): Date: /  |   |   |  |  |  |  |  |
| Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent |   |   |  |  |  |  |  |
| insurance act, which is a crime and subjects such person to criminal and civil penalties.   |   |   |  |  |  |  |  |
|   | - Required clinical information must be conclinical documentation required for all required a result of the patient receiving samples of Active used concomitantly with apremilast, tofacition supporting disease stability?  Identify the patient receiving samples of Active used concomitantly with apremilast, tofacition supporting disease improvement?  Identify the patient of the past year?  Identify the performance of the past year?  Interferon-gammate the results of the TB test: Results: □ Position of therapy requests only):  Interferon (tocilizumab) within the past 6 months?  Interferon the patient of the patient have a documented severe and/or potential infusion?  No Could the adverse reaction be managed the sumatoid arthritis, rheumatoid arthritis or thritis at baseline (pretreatment with Actemination):  Interferon the patient patie | - Required clinical information must be completed in its entirety for all predictional documentation required for all requests):  a result of the patient receiving samples of Actemra (tocilizumab)?  be used concomitantly with apremilast, tofacitinib, or other biologic DMARDs (elion supporting disease stability?  ion supporting disease improvement?  isk factors for TB?  tient had a TB test within the past year?  that apply): □ PPD test □ interferon-gamma assay (IGRA) □ chest x-ray er the results of the TB test: Results: □ Positive □ Negative □ Unknown tion of therapy requests only):  Stemma (tocilizumab) within the past 6 months?  attent have a documented severe and/or potentially life-threatening adverse evis infusion?  No Could the adverse reaction be managed through pre-medication in the homographic present in the process of the present of the pr |  |  |  |  |  |

The plan may request additional information or clarification, if needed, to evaluate requests.