



# TOCILIZUMAB (ACTEMRA®)

## PRIOR REVIEW/CERTIFICATION FAXBACK FORM

**INCOMPLETE FORMS MAY DELAY PROCESSING  
ALL NC PROVIDERS MUST PROVIDE THEIR 5-DIGIT BCBSNC PROVIDER ID# BELOW**

PRESCRIBER INFORMATION		PATIENT INFORMATION
PHYSICIAN NAME	PROVIDER ID/TAX ID (if out of state must have tax ID)	PATIENT NAME
CONTACT PERSON/PRACTICE NAME		PATIENT'S BCBSNC ID
PRACTICE PHONE	PRACTICE FAX	PATIENT'S DATE OF BIRTH
PRACTICE ADDRESS	CITY	STATE
		ZIP

**Please answer the following questions:** **Dx Code:** \_\_\_\_\_

1. Is this drug being prescribed for moderate to severely active rheumatoid arthritis? .....  Yes  No
2. Has the patient tried a tumor necrosis factor (TNF) antagonist (Enbrel, Humira, Remicade, Cimzia, Simponi) for rheumatoid arthritis and had an inadequate response? .....  Yes  No
3. Has the patient been screened for the presence of latent TB infection?.....  Yes  No
4. Will the patient be receiving more than one biologic agent at the same time?.....  Yes  No
5. Is the patient new to therapy with Actemra? .....  Yes  No
6. If the patient is new to Actemra therapy, does the patient have an absolute neutrophil count (ANC) *below* 2000/mm<sup>3</sup>, platelet count *below* 100,000/ mm<sup>3</sup>, or ALT or AST *above* .. 1.5 times the upper limit of normal (ULN)? .....  Yes  No  N/A

**\*\*\*NOTE:** *If you are prescribing greater than 800mg every 28 days of Actemra, please complete and sign page 2*

**Please certify the following by signing and dating below:**

I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that BCBSNC may request medical records for this patient at any time in order to verify this information. I further understand that if BCBSNC determines this information is not reflected in my patient's medical records, BCBSNC may request a refund of any payments made and/or pursue any other remedies available.

Prescriber's Signature (Required): \_\_\_\_\_ Date: \_\_\_\_\_

**For BCBSNC members, fax form to 1-800-795-9403  
For NC State Health Plan members, fax form to 1-866-225-5258**

**COMPLETE PAGE 2 ONLY REQUEST QUANTITY LIMIT  
EXCEPTION FOR ACTEMRA**

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PHYSICIAN NAME	PROVIDER ID/TAX ID (if out of state must have tax ID)	PATIENT NAME
CONTACT PERSON/PRACTICE NAME		PATIENT'S BCBSNC ID
PRACTICE PHONE	PRACTICE FAX	PATIENT'S DATE OF BIRTH
PRACTICE ADDRESS	CITY	STATE ZIP

**If you are requesting a quantity above the amount listed, check the appropriate box and provide the medical necessity of the increased dosage requested.**

*Please note: This medication requires a **prior authorization** before a quantity limit override can be considered. Before submitting a request for a quantity level override, please ensure that a prior approval authorization has been submitted and/or approved (page 1). Otherwise, this request will deny.*

**Dx Code:** \_\_\_\_\_

Requested drug dose:

greater than **800mg every 28 days** of Actemra

Provide dosage requested and a description of medical necessity / rationale for this request:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please certify the following by signing and dating below:

I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that BCBSNC may request medical records for this patient at any time in order to verify this information. I further understand that if BCBSNC determines this information is not reflected in my patient's medical records, BCBSNC may request a refund of any payments made and/or pursue any other remedies available.

Prescriber's Signature (Required): \_\_\_\_\_ Date: \_\_\_\_\_

**For BCBSNC members, fax form to 1-800-795-9403  
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