tocilizumab (Actemra®) and tocilizumab biosimilars

INTRAVENOUS INFUSION AND SUBCUTANEOUS INJECTION FOR ADMINISTRATION BY A HEALTHCARE PROFESSIONAL

PRIOR REVIEW/CERTIFICATION REQUEST FOR SERVICES FORM

INCOMPLETE FORMS MAY DELAY PROCESSING

ALL NC PROVIDERS MUST PROVIDE THEIR 5-DIGIT Blue Cross NC PROVIDER ID# BELOW

PATIENT NAME	BLUE CROSS NC MEMBER ID NUMBER	PATIENT DATE OF BIRTH

REQUESTING PROVIDER INFORMATION		SERVICING PROVIDER OR FACILITY LOCATION (for services to be performed outside of the physician office)	
Provider Name		Servicing Provider	
Provider #, Tax ID # or NPI		Facility Name	
Street, Bldg., Suite #		Servicing provider or Facility #, NPI #	
City/State/Zip code		Street, Bldg., Suite #	
Phone #		City/State/Zip code	
Fax #			

PLACE OF SERVICE: ☐ Home Infusion ☐ Office ☐ Outpatient hospital ☐ Specialty Pharmacy

Specialty Pharmacy:	**Specialty Pharmacy NPI:**
HCPCS CODE:	**CPT/Other billing code:**
Primary Diagnosis:	**ICD-10:**
Drug Requested:	
Strength & Route of Administration:	

Please select the requested medication and answer the following questions for INITIAL coverage:

*See page 6 for continuation coverage for diagnosis of **SSc-ILD only***

☐ tocilizumab IV (Actemra IV) – J3262 ☐ tocilizumab SC (Actemra SC) – C9399**, J3490**, J3590**

☐ tocilizumab-anoh (Avtozma) – Q5156 ☐ tocilizumab-bavi (Tofidence) – Q5133 ☐ tocilizumab-aazq (Tyenne) – Q5135

1. Will the requested medication be administered by a healthcare professional and billed under the medical benefit?..... ☐ Yes ☐ No
   If NO, please do not continue filling out this form. Please complete the Actemra – Self-Administered Subcutaneous Use form.
2. Is the prescriber a specialist in the area of the patient's diagnosis (e.g., rheumatologist for RA, JIA, GCA, SSc-ILD; oncologist for CRS; pulmonologist for SSc-ILD) or has consulted with a specialist in the area of the patient's diagnosis?..... ☐ Yes ☐ No
3. Will the patient be using the requested medication in combination with another biologic immunomodulator agent or Otezla?..... ☐ Yes ☐ No
4. Does the patient have any FDA labeled contraindications to the requested medication?..... ☐ Yes ☐ No
5. Has the patient been tested for latent tuberculosis (TB) when required by the prescribing information?..... ☐ Yes ☐ No
   a. **If YES**, was the TB test positive?..... ☐ Yes ☐ No
      i. **If YES,** has the patient begun therapy for latent TB?..... ☐ Yes ☐ No

****Continued on page 2; please complete and sign **page 5** for prior authorization request****

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tocilizumab (Actemra®) and tocilizumab biosimilars - *continued*

6. Is the request for Actemra (tocilizumab) or a non-preferred tocilizumab biosimilar product [e.g., Tofidence (tocilizumab-bavi)]?.....☐ Yes ☐ No
   If YES, please answer the following questions and submit medical record documentation:
   a. Has the patient tried and had an inadequate response to the following preferred tocilizumab biosimilar product: Tyenne® (tocilizumab-aazg)?.....☐ Yes ☐ No
   b. Has the patient tried and had an inadequate response to the following preferred tocilizumab biosimilar product: Avtozma (toxilizumab-anoh)?.....☐ Yes ☐ No
   c. Does the patient have an intolerance, FDA labeled contraindication, or hypersensitivity to ALL preferred tocilizumab biosimilar products (i.e.,Tyenne and Avtozma) that is NOT expected to occur with the requested medication?.....☐ Yes ☐ No
   d. Has the patient had a documented serious adverse event that required medical intervention to BOTH Tyenne and Avtozma that is NOT anticipated with the requested medication?.....☐ Yes ☐ No
      i. **If YES,** has the prescriber completed and submitted an FDA MedWatch Adverse Event Reporting Form for each incident?.....☐ Yes ☐ No
      Please submit a copy of the FDA MedWatch form(s).

7. Does the patient have a diagnosis of moderately to severely active **rheumatoid arthritis (RA)**?.....☐ Yes ☐ No
   If YES, please answer the following questions and submit medical record documentation confirming previously tried and/or contraindicated therapies:
   a. Is the patient 18 years of age or older?.....☐ Yes ☐ No
   b. Has the patient tried and had an inadequate response to maximally tolerated methotrexate (e.g. titrated to 25mg weekly) for at least 3-months?.....☐ Yes ☐ No
   c. Has the patient tried and had an inadequate response to another conventional agent (i.e., hydroxychloroquine, leflunomide, sulfasalazine) used in the treatment of RA for at least 3-months?.....☐ Yes ☐ No
   d. Does the patient have an intolerance or hypersensitivity to **ONE** of the following conventional agents (i.e., maximally tolerated methotrexate, hydroxychloroquine, leflunomide, sulfasalazine) used in the treatment of RA?.....☐ Yes ☐ No
   e. Does the patient have an FDA labeled contraindication to **ALL** of the following conventional agents (i.e., maximally tolerated methotrexate, hydroxychloroquine, leflunomide, sulfasalazine) used in the treatment of RA?.....☐ Yes ☐ No
   f. Is the patient established on a biologic or systemic immunomodulator agent (excluding sample use) that is FDA approved for the treatment of RA?.....☐ Yes ☐ No
   If YES, please submit medical record documentation.
   i. Has the patient tried and had an inadequate response to either of the following:
      i. an infliximab product?.....☐ Yes ☐ No
      ii. Simponi Aria® (golimumab)?.....☐ Yes ☐ No
   g. Does the patient have an intolerance, FDA labeled contraindication or hypersensitivity to **BOTH** an infliximab product AND Simponi Aria® (golimumab)?.....☐ Yes ☐ No
   h. Please provide information why ALL of the preferred medications (i.e., infliximab products and Simponi Aria) are not clinically appropriate for the patient *(omission of information indicates N/A or none)*: _____
   _____
   i. Please provide a complete list of previously tried medications that the member has tried for the diagnosis of RA *(omission of information indicates N/A or none)*: _____
   _____

****Continued on page 3; please complete and sign **page 5** for prior authorization request****

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tocilizumab (Actemra®) and tocilizumab biosimilars - *continued*

8. Does the patient have a diagnosis of **giant cell arteritis (GCA)**?.....☐ Yes ☐ No
   If YES, please answer the following questions and submit medical record documentation confirming previously tried and/or contraindicated therapies:
   a. Is the patient 18 years of age or older?.....☐ Yes ☐ No
   b. Has the patient tried and had an inadequate response to systemic corticosteroids (e.g., prednisone, methylprednisolone) used in the treatment of GCA for at least 7-10 days?.....☐ Yes ☐ No
   c. Does the patient have an intolerance or hypersensitivity to systemic corticosteroids used in the treatment of GCA?.....☐ Yes ☐ No
   d. Does the patient have an FDA labeled contraindication to **ALL** systemic corticosteroids used in the treatment of GCA?.....☐ Yes ☐ No
   e. Is the patient established on a biologic or systemic immunomodulator agent (excluding sample use) that is FDA approved for the treatment of GCA?.....☐ Yes ☐ No
      If YES, please submit medical record documentation.

9. Does the patient have a diagnosis of moderately to severely active **polyarticular juvenile idiopathic arthritis (PJIA)**?.....☐ Yes ☐ No
   If YES, please answer the following questions and submit medical record documentation confirming previously tried and/or contraindicated therapies:
   a. Is the patient 2 years of age or older?.....☐ Yes ☐ No
   b. Has the patient tried and had an inadequate response to **ONE** conventional agent (i.e., methotrexate, leflunomide) used in the treatment of PJIA for at least 3-months?.....☐ Yes ☐ No
   c. Does the patient have an intolerance or hypersensitivity to **ONE** of the conventional agents used in the treatment of PJIA?.....☐ Yes ☐ No
   d. Does the patient have an FDA labeled contraindication to **ALL** of the conventional agents used in the treatment of PJIA?.....☐ Yes ☐ No
   e. Is the patient established on a biologic or systemic immunomodulator agent (excluding sample use) that is FDA approved for the treatment of PJIA?.....☐ Yes ☐ No
      If YES, please submit medical record documentation.

10. Does the patient have a diagnosis of active **systemic juvenile idiopathic arthritis (SJIA)**?.....☐ Yes ☐ No
    If YES, please answer the following questions and submit medical record documentation confirming previously tried and/or contraindicated therapies:
    a. Is the patient 2 years of age or older?.....☐ Yes ☐ No
    b. Has the patient tried and had an inadequate response to at least **ONE** NSAID (e.g., ibuprofen, celecoxib) used in the treatment of SJIA for at least 1-month?.....☐ Yes ☐ No
    c. Does the patient have an intolerance or hypersensitivity to NSAIDs used in the treatment of SJIA?.....☐ Yes ☐ No
    d. Does the patient have an FDA labeled contraindication to **ALL** NSAIDs used in the treatment of SJIA?.....☐ Yes ☐ No
    e. Has the patient tried and had an inadequate response to another conventional agent (i.e., methotrexate, leflunomide, systemic corticosteroids, azathioprine, cyclosporine, tacrolimus) used in the treatment of SJIA for at least 3-months?.....☐ Yes ☐ No
    f. Does the patient have an intolerance or hypersensitivity to **ONE** of the conventional agents used in the treatment of SJIA?.....☐ Yes ☐ No

****Continued on page 4; please complete and sign **page 5** for prior authorization request****

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tocilizumab (Actemra®) and tocilizumab biosimilars – *continued*

Diagnosis of active **systemic juvenile idiopathic arthritis (SJIA) – *continued***

g. Does the patient have an FDA labeled contraindication to **ALL** of the conventional agents used in the treatment of SJIA?..... ☐ Yes ☐ No

h. Is the patient established on a biologic or systemic immunomodulator agent (excluding sample use) that is FDA approved for the treatment of SJIA?..... ☐ Yes ☐ No
If YES, please submit medical record documentation.

11. Does the patient have a diagnosis of severe or life-threatening **cytokine release syndrome (CRS)**?..... ☐ Yes ☐ No
If YES, please answer the following questions:
   a. Is the patient 2 years of age or older?..... ☐ Yes ☐ No
   b. Is the request for intravenous administration?..... ☐ Yes ☐ No
   c. Has the patient received or will be receiving CAR-T cell therapy?..... ☐ Yes ☐ No
   If YES, please submit medical record documentation.
   d. Was the CRS induced by chimeric antigen receptor (CAR) T cell therapy?..... ☐ Yes ☐ No
   If YES, please submit medical record documentation.
   e. Is the requested medication being prescribed proactively to have on-hand, prior to the administration of CAR-T cell therapy, if needed for the treatment of CRS?..... ☐ Yes ☐ No
   If YES, please submit medical record documentation.

12. Does the patient have a diagnosis of **systemic sclerosis-associated interstitial lung disease (SSc-ILD)**?..... ☐ Yes ☐ No
If YES, please answer the following questions and submit medical record documentation confirming previously tried and/or contraindicated therapies:
   a. Is the patient 18 years of age or older?..... ☐ Yes ☐ No
   b. Did the patient have disease onset (e.g., first non-Raynaud symptom) within the past 5 years?..... ☐ Yes ☐ No
   c. Does the patient have elevated laboratory inflammatory markers (e.g., acute-phase reactant levels, C-reactive protein, ESR, or platelet count)?..... ☐ Yes ☐ No
   d. Does the patient have active disease, as defined by any of the following:
      i. Disease duration of 18 months or less?..... ☐ Yes ☐ No
      ii. Increase in mRSS (modified Rodnan skin score) of at least 3 units over 6 months?..... ☐ Yes ☐ No
      iii. Involvement of one new body area and an increase in mRSS of at least 2 units over 6 months?..... ☐ Yes ☐ No
      iv. Involvement of two new body areas within the previous 6 months?..... ☐ Yes ☐ No
      v. Presence of at least one tendon friction rub?..... ☐ Yes ☐ No
   e. Has the diagnosis of SSc-ILD been confirmed by the presence of characteristic features of interstitial lung disease (ILD) on chest high-resolution computed tomography (HRCT)?..... ☐ Yes ☐ No
   f. Have other known causes of ILD been excluded (e.g., heart failure, drug-induced lung toxicity, recurrent aspiration, pulmonary vascular disease)?..... ☐ Yes ☐ No

****Continued on page 5; please complete and sign **page 5** for prior authorization request****

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tocilizumab (Actemra®) and tocilizumab biosimilars – *continued*

Diagnosis of **systemic sclerosis-associated interstitial lung disease (SSc-ILD) – *continued***

g. Has the patient tried and had an inadequate response to **ONE** immunosuppressant therapy (e.g., mycophenolate mofetil, cyclophosphamide, azathioprine) used in the treatment of SSc-ILD?.....☐ Yes ☐ No

h. Does the patient have an intolerance or hypersensitivity to **ONE** immunosuppressant therapy used in the treatment of SSc-ILD?.....☐ Yes ☐ No

i. Does the patient have an FDA labeled contraindication to **ALL** immunosuppressant therapy used in the treatment of SSc-ILD?.....☐ Yes ☐ No

j. Is the patient established on a biologic or systemic immunomodulator agent (excluding sample use) that is FDA approved for the treatment of SSc-ILD?.....☐ Yes ☐ No
YES, please submit medical record documentation.

14. Will the patient be using the requested medication for indications outside of FDA labeling?.....☐ Yes ☐ No
If YES, please indicate condition: _____
Medical records and references/evidence must be provided in order for this request to be processed.

15. Will the injection or infusion of the requested medication be administered in an **inpatient or outpatient hospital setting**?.....☐ Yes ☐ No
If YES, please answer the Site of Care questions on pages 9-10.

16. Is the requested quantity within the maximum units allowed (see table on pages 10-11)?.....☐ Yes ☐ No
If NO, please complete page 8 for a quantity limit exception.

17. Please provide the patient's current weight and dosing regimen:
    a. Current weight: _____ ☐ kg ☐ lbs
    b. Current dose: _____
    c. Dosing frequency: _____

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 Blue Cross NC may request medical records for this patient at any time in order to verify this information. I further understand that if Blue Cross NC determines this information is not reflected in my patient's medical records, Blue Cross NC may request a refund of any payments made and/or pursue any other remedies available.
Prescriber's Signature (Required):_____ **Date**:_____

For Blue Cross NC members, fax form to 1-888-348-7332

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tocilizumab (Actemra®) and tocilizumab biosimilars - CONTINUATION

INTRAVENOUS INFUSION AND SUBCUTANEOUS INJECTION FOR ADMINISTRATION BY A HEALTHCARE PROFESSIONAL

PRIOR REVIEW/CERTIFICATION REQUEST FOR SERVICES FORM

INCOMPLETE FORMS MAY DELAY PROCESSING

ALL NC PROVIDERS MUST PROVIDE THEIR 5-DIGIT Blue Cross NC PROVIDER ID# BELOW

PATIENT NAME	BLUE CROSS NC MEMBER ID NUMBER	PATIENT DATE OF BIRTH

REQUESTING PROVIDER INFORMATION		SERVICING PROVIDER OR FACILITY LOCATION (for services to be performed outside of the physician office)	
Provider Name		**Servicing Provider**	
Provider #, Tax ID # or NPI		**Facility Name**	
Street, Bldg., Suite #		**Servicing provider or Facility #, or NPI #**	
City/State/Zip code		**Street, Bldg., Suite #**	
Phone #		**City/State/Zip code**	
Fax #			

PLACE OF SERVICE: ☐ Home Infusion ☐ Office ☐ Outpatient hospital ☐ Specialty Pharmacy

Specialty Pharmacy:	**Specialty Pharmacy NPI:**
HCPCS CODE:	**CPT/Other billing code:**
Primary Diagnosis:	**ICD-10:**
Drug Requested:	
Strength & Route of Administration:	

Please select the requested medication and answer the following questions for CONTINUATION coverage:

Please note: continuation coverage for diagnosis of **SSc-ILD only*

☐ tocilizumab IV (Actemra IV) – J3262 ☐ tocilizumab SC (Actemra SC) – C9399**, J3490**, J3590**

☐ tocilizumab-anoh (Avtozma) – Q5156 ☐ tocilizumab-bavi (Tofidence) – Q5133 ☐ tocilizumab-aazq (Tyenne) – Q5135

1. Does the patient have a diagnosis of **systemic sclerosis-associated interstitial lung disease (SSc-ILD)**?.....☐ Yes ☐ No
   If YES, please answer the following questions. If NO, please answer all questions on pages 1-5.
2. Was the patient approved for initial coverage for the requested medication through Blue Cross NC?.....☐ Yes ☐ No
   If NO, please answer all questions on pages 1-5. If YES, please answer the following questions:
3. Will the requested medication be administered by a healthcare professional and billed under the medical benefit?.....☐ Yes ☐ No
   If NO, please do not continue filling out this form. Please complete the Actemra – Self-Administered Subcutaneous Use form.
4. Has the patient had a positive clinical response while using the requested medication, as demonstrated by improved or maintained annual rate of decline in pulmonary function (i.e., predicted forced vital capacity [FVC% predicted])?.....☐ Yes ☐ No

****Continued on page 7; please complete and sign **page 7** for prior authorization request****

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tocilizumab (Actemra®) and tocilizumab biosimilars - *continued*

4. Is the request for Actemra (tocilizumab) or a non-preferred tocilizumab biosimilar product [e.g., Tofidence (tocilizumab-bavi)]?.....☐ Yes ☐ No
   If YES, please answer the following questions and submit medical record documentation:
   a. Has the patient tried and had an inadequate response to the following preferred tocilizumab biosimilar product: Tyenne® (tocilizumab-aazg)?.....☐ Yes ☐ No
   b. Has the patient tried and had an inadequate response to the following preferred tocilizumab biosimilar product: Avtozma (toxilizumab-anoh)?.....☐ Yes ☐ No
   c. Does the patient have an intolerance, FDA labeled contraindication, or hypersensitivity to ALL preferred tocilizumab biosimilar products (i.e.,Tyenne and Avtozma) that is NOT expected to occur with the requested medication?.....☐ Yes ☐ No
   d. Has the patient had a documented serious adverse event that required medical intervention to BOTH Tyenne and Avtozma that is NOT anticipated with the requested medication?☐ Yes ☐ No
      i. **If YES,** has the prescriber completed and submitted an FDA MedWatch Adverse Event Reporting Form for each incident?.....☐ Yes ☐ No
      Please submit a copy of the FDA MedWatch form(s).

5. Is the prescriber a specialist in the area of the patient's diagnosis (e.g., rheumatologist for SSc-ILD; pulmonologist for SSc-ILD) or has consulted with a specialist in the area of the patient's diagnosis?.....☐ Yes ☐ No

6. Will the patient be using the requested medication in combination with another biologic immunomodulator agent or Otezla?.....☐ Yes ☐ No

7. Will the injection or infusion of the requested medication be administered in an **inpatient or outpatient hospital setting**?.....☐ Yes ☐ No
   If YES, please answer the Site of Care questions on pages 9-10.

8. Is the requested quantity within the maximum units allowed (see table on pages 10-11)?.....☐ Yes ☐ No
   If NO, please complete page 8 for a quantity limit exception.

9. Please provide the patient's current weight and dosing regimen:
   a. Current weight: _____ ☐ kg ☐ lbs
   b. Current dose: _____
   c. Dosing frequency: _____

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 Blue Cross NC may request medical records for this patient at any time in order to verify this information. I further understand that if Blue Cross NC determines this information is not reflected in my patient's medical records, Blue Cross NC may request a refund of any payments made and/or pursue any other remedies available.
Prescriber's Signature (Required):_____ **Date**:_____

For Blue Cross NC members, fax form to 1-888-348-7332

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tocilizumab (Actemra®) and tocilizumab biosimilars - QUANTITY LIMIT EXCEPTION

INTRAVENOUS INFUSION AND SUBCUTANEOUS INJECTION FOR ADMINISTRATION BY A HEALTHCARE PROFESSIONAL

PATIENT NAME	BLUE CROSS NC MEMBER ID NUMBER	PATIENT DATE OF BIRTH

REQUESTING PROVIDER INFORMATION		SERVICING PROVIDER OR FACILITY LOCATION (for services to be performed outside of the physician office)	
Provider Name		**Servicing Provider**	
Provider #, Tax ID # or NPI		**Facility Name**	
Street, Bldg., Suite #		**Servicing provider or Facility #, or NPI #**	
City/State/Zip code		**Street, Bldg., Suite #**	
Phone #		**City/State/Zip code**	
Fax #			

PLACE OF SERVICE: ☐ Home Infusion ☐ Office ☐ Outpatient hospital ☐ Specialty Pharmacy

Specialty Pharmacy:	**Specialty Pharmacy NPI:**
HCPCS CODE:	**CPT/Other billing code:**
Primary Diagnosis:	**ICD-10:**
Drug Requested:	
Strength & Route of Administration:	

FOR COVERAGE OVER THE FDA LABELED DOSING (SEE PAGES 10-11), PLEASE SELECT THE REQUESTED MEDICATION AND ANSWER THE FOLLOWING: ***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 (pages 1-5 or pages 6-7). Otherwise, this request will deny.*

☐ tocilizumab IV (Actemra IV) – J3262 ☐ tocilizumab SC (Actemra SC) – C9399**, J3490**, J3590**

☐ tocilizumab-anoh (Avtozma) – Q5156 ☐ tocilizumab-bavi (Tofidence) – Q5133 ☐ tocilizumab-aazq (Tyenne) – Q5135

Requested units: _____

Please enter quantity as a numeric value with one decimal place (ex. 1.0, 1.5)*

In the space provided, please document support for the requested Quantity Limit Exception (this may include documented clinical rationale and/or medical records). **Rationale must be submitted.**

_____

_____

_____

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 Blue Cross NC may request medical records for this patient at any time in order to verify this information. I further understand that if Blue Cross NC determines this information is not reflected in my patient's medical records, Blue Cross NC may request a refund of any payments made and/or pursue any other remedies available.
Prescriber's Signature (Required):_____ **Date**:_____

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tocilizumab (Actemra®) and tocilizumab biosimilars - SITE OF CARE

INTRAVENOUS INFUSION AND SUBCUTANEOUS INJECTION FOR ADMINISTRATION BY A HEALTHCARE PROFESSIONAL

PATIENT NAME	BLUE CROSS NC MEMBER ID NUMBER	PATIENT DATE OF BIRTH

REQUESTING PROVIDER INFORMATION		SERVICING PROVIDER OR FACILITY LOCATION (for services to be performed outside of the physician office)	
Provider Name		**Servicing Provider**	
Provider #, Tax ID # or NPI		**Facility Name**	
Street, Bldg., Suite #		**Servicing provider or Facility #, or NPI #**	
City/State/Zip code		**Street, Bldg., Suite #**	
Phone #		**City/State/Zip code**	
Fax #			

PLACE OF SERVICE: ☐ Home Infusion ☐ Office ☐ Outpatient hospital ☐ Specialty Pharmacy

Specialty Pharmacy:	**Specialty Pharmacy NPI:**
HCPCS CODE:	**CPT/Other billing code:**
Primary Diagnosis:	**ICD-10:**
Drug Requested:	
Strength & Route of Administration:	

PLEASE SELECT THE REQUESTED MEDICATION AND ANSWER THE FOLLOWING QUESTIONS:

Please note: *This medication requires a* ***prior authorization*** *before Site of Care can be considered. Before submitting a request for Site of Care, please ensure that a prior approval authorization has been submitted and/or approved (pages 1-5 or pages 6-7). Otherwise, this request will deny.*

☐ tocilizumab IV (Actemra IV) – J3262 ☐ tocilizumab SC (Actemra SC) – C9399**, J3490**, J3590**

☐ tocilizumab-anoh (Avtozma) – Q5156 ☐ tocilizumab-bavi (Tofidence) – Q5133 ☐ tocilizumab-aazq (Tyenne) – Q5135

1. Is the injection/infusion being administered in an **inpatient setting**?.....☐ Yes ☐ No
   If YES, please answer the following questions:
   a. Is the sole purpose of the inpatient admission for giving the injection/infusion?.....☐ Yes ☐ No
   b. Is this an **emergent** admission/request (the patient presented to the hospital via emergency room or transferred inpatient from another facility)?.....☐ Yes ☐ No
2. Is the injection/infusion being administered in an **outpatient hospital setting**?.....☐ Yes ☐ No
   If YES, please answer the following questions:
   a. Does the patient have a history of a severe adverse event following the injection or infusion of the requested medication (i.e., anaphylaxis, seizure, thromboembolism, myocardial infarction, renal failure)?.....☐ Yes ☐ No
   b. Does the patient have any of the following conditions that cause an increased risk for a severe adverse event:
      i. unstable renal function? .....☐ Yes ☐ No
      ii. cardiopulmonary conditions? .....☐ Yes ☐ No
      iii. unstable vascular access? .....☐ Yes ☐ No
   c. Does the patient have a history of mild adverse events that have not been successfully managed through mild pre-medication (e.g., diphenhydramine, acetaminophen, steroids, fluids, etc.)?.....☐ Yes ☐ No

****Continued on page 10, please complete and sign* ***page 10*** *for Site of Care request****

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tocilizumab (Actemra®) and tocilizumab biosimilars – SITE OF CARE

INTRAVENOUS INFUSION AND SUBCUTANEOUS INJECTION FOR ADMINISTRATION BY A HEALTHCARE PROFESSIONAL

d. Is the patient unable to physically and cognitively adhere to the treatment schedule and regimen complexity?..... ☐ Yes ☐ No
e. Is the patient new to therapy (defined as initial injection/infusion OR less than 3 months since the initial injection/infusion)?..... ☐ Yes ☐ No
f. Is this the first injection/infusion after 6 months of no injections/infusions for medications with approved dosing intervals of less than 6 months?..... ☐ Yes ☐ No
g. Is this the first injection/infusion after at least a 1-month gap in therapy outside of the approved dosing interval for medications requiring every 6 months dosing duration?..... ☐ Yes ☐ No
h. Is this request required due to a change in formulation of the requested medication?..... ☐ Yes ☐ No

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 Blue Cross NC may request medical records for this patient at any time in order to verify this information. I further understand that if Blue Cross NC determines this information is not reflected in my patient's medical records, Blue Cross NC may request a refund of any payments made and/or pursue any other remedies available.
Prescriber's Signature (Required):_____ **Date**:_____

For Blue Cross NC members, fax form to 1-888-348-7332

FDA Label Reference				
Medication	**Indication**	**Dosing**	**HCPCS**	**Maximum Units***
tocilizumab (Actemra®) intravenous (IV) infusion, subcutaneous (SC) injection	RA in patients ≥18 years old	SC: • weight <100 kg: 162 mg every 2 weeks, up to once weekly based on response • weight ≥100 kg: 162 mg once weekly IV: 4 mg/kg every 4 weeks, up to 8 mg/kg every 4 weeks based on response, not to exceed 800 mg per infusion	IV: J3262 SC: C9399** J3490** J3590*	CRS: 3,200 All other diagnoses: 20,800
	GCA in patients ≥18 years old	SC: 162 mg once weekly, or every other week may be considered IV: 6 mg/kg every 4 weeks, not to exceed 600 mg per infusion		
tocilizumab-anoh (Avtozma®) intravenous (IV) infusion, subcutaneous (SC) injection	PJIA in patients ≥2 years old	SC: • weight <30 kg: 162 mg every 3 weeks • weight ≥30 kg: 162 mg every 2 weeks IV: Administered every 4 weeks • weight <30 kg: 10 mg/kg weight ≥30 kg: 8 mg/kg	Q5156	
	SJIA in patients ≥2 years old	SC: • weight <30 kg: 162 mg every 2 weeks • weight ≥30 kg: 162 mg once weekly		

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		IV: Administered every 2 weeks • weight <30 kg: 12 mg/kg weight ≥30 kg: 8 mg/kg		
tocilizumab-bavi (Tofidence™) intravenous (IV) infusion	CRS in patients ≥2 years old (IV)	IV: Up to 4 doses with interval between consecutive doses of at least 8 hours, not to exceed 800 mg per infusion • weight <30 kg: 12 mg/kg weight ≥30 kg: 8 mg/kg	Q5133	
	SSc-ILD in patients ≥18 years old (SC)	SC: 162 mg once weekly		
tocilizumab-aazg (Tyenne®) intravenous (IV) infusion, subcutaneous (SC) injection			Q5135	

***Maximum units allowed for duration of approval**
****Non-specific assigned HCPCS codes, must submit requested product NDC**

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