Blue Cross Blue Shield/Blue Care Network of Michigan
Medication Authorization Request Form

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licens of the Blue Cross and Blue Shield Association

This form is to be used by participating physicians to obtain coverage for **drugs covered under the medical benefit**. For commercial members only, please complete this form and submit via fax to 1-877-325-5979. If you have any questions regarding this process, please contact BCBSM Provider Relations and Servicing or the Medical Drug Helpdesk at 1-800-437-3803 for assistance.

PATIENT INFORMATION		PHYSICIAN INFORMATION
Name		**Name**
ID Number		**Specialty**
D.O.B.	_____/_____/_____ MM/DD/YYYY ❑Male ❑Female	**Address**
Diagnosis		**City /State/Zip**
Drug Name	**Actemra SC**	**Phone:** **Fax:**
Dose and Quantity		**NPI**
Directions		**Contact Person**
Date of Service(s)		**Contact Person** **Phone / Ext.**

STEP 1: DISEASE STATE INFORMATION

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*ft* _____*inches*

Will the provider be administering the medication to the FEP member within the health plan's geographic service area?

❑ Yes ❑ No *If No, a prior authorization is not required through this process.*

Prior authorizations are required for FEP members that will be serviced by a provider within the health plan's geographic service area. If you are not a provider in the geographic service area, please contact the health plan for questions regarding the FEP member's benefit requirements.

Is this member's FEP coverage primary or secondary coverage?

❑ If primary, continue with questionset.

❑ If secondary, **an authorization is not needed through this process. Please contact the member's primary coverage for determination of benefit and additional information.**

Site of Care:

A. At what location will the member be receiving the requested medication?

❑ Physician's office, home infusion, non-hospital affiliated ambulatory infusion center.

❑ Outpatient hospital infusion center. Please provide the name of the infusion center and rationale why the patient must receive this medication in a hospital outpatient setting.

_____

❑ Other. Please specify. _____

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

1. Has the patient been on Actemra therapy 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 **Continuation Section**
   ❑ **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 Actemra therapy? ❑Yes ❑No
7. Will Actemra 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, Cimzia, Cosentyx, Enbrel, Entyvio, Humira, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Riabni, Rinvoq, Rituxan, Ruxience, Siliq, Simponi/Simponi Aria, Skyrizi, Stelara, Taltz, Tremfya, Truxima, and Xeljanz/Xeljanz XR
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 Actemra within the FDA labeled maintenance dose of 162mg every week? ❑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. Does the prescriber agree to administer Actemra within the FDA labeled maintenance dose of 162mg every week? ❑Yes ❑No

   ❑Polyarticular Juvenile Idiopathic Arthritis (pJIA)
   a. Is the patient's arthritis active? ❑Yes ❑No
   b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a 3 month trial of at least one conventional DMARD? ❑Yes ❑No
   c. What is the patient's weight? ***Please select answer below:***
      ❑ **Less than 30kg (66lbs):** Does the prescriber agree to administer Actemra 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 Actemra 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 Actemra 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 Actemra 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 Actemra as a subcutaneous dose and not by IV administration? ❑Yes ❑No
   b. Does the prescriber agree to administer Actemra within the FDA labeled maintenance dose of 162mg every week? ❑Yes ❑No

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

CONTINUATION OF ACTEMRA SUBCUTANEOUS THERAPY (PA RENEWAL)

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

1. Has the patient's condition improved or stabilized with Actemra? ❑Yes ❑No
2. Does the patient have any active infections including tuberculosis (TB) or hepatitis B virus (HBV)? ❑Yes ❑No
3. Will the patient be given live vaccines while on Actemra therapy? ❑Yes ❑No
4. Is Actemra going to 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, Cimzia, Cosentyx, Enbrel, Entyvio, Humira, Ilumya, Inflectra, Kevzara, Kineret, Olumiant, Orencia, Otezla, Remicade, Renflexis, Riabni, Rinvoq, Rituxan, Ruxience, Siliq, Simponi/Simponi Aria, Skyrizi, Stelara, Taltz, Tremfya, Truxima, and Xeljanz/Xeljanz XR
5. What is the patient's diagnosis?

   ❑Giant cell arteritis
   a. Does the prescriber agree to administer Actemra within the FDA labeled maintenance dose of 162mg every week? ❑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 Actemra 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 Actemra within the FDA labeled maintenance dose of 162mg every 2 weeks? ❑Yes ❑No

   ❑ Rheumatoid Arthritis (RA)
   a. Does the prescriber agree to administer Actemra 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 Actemra 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 Actemra 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 Actemra within the FDA labeled maintenance dose of 162mg every week? ❑Yes ❑No

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

Chart notes are required for the processing of all requests. Please add any other supporting medical information necessary for our review **(required)**

Coverage will not be provided if the prescribing physician's signature and date are not reflected on this document.

❑ Request for expedited review: I certify that applying the standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function

Physician's Name	**Physician Signature**	**Date**
Step 2: Checklist	❑ Form Completely Filled Out ❑ Provide chart notes	❑ Attach test results
Step 3: Submit	**By Fax: BCBSM Specialty Pharmacy Mailbox 1-877-325-5979**	**By Mail: BCBSM Specialty Pharmacy Program P.O. Box 312320, Detroit, MI 48231-2320**