Actemra® SC (tocilizumab)

Medication Request Form (MRF) for Healthy Indiana Plan (HIP) and Hoosier Healthwise (HHW)

FAX TO: (858) 790-7100

c/o MedImpact Healthcare Systems, Inc.

Attn: Prior Authorization Department
10181 Scripps Gateway Court, San Diego, CA 92131 - Phone: 1-800-788-2949

Instructions:

This form is to be used by participating providers to obtain coverage for the drug listed above which requires *prior authorization*. Please complete this form and fax it to *Med**Impact*** Healthcare Systems, Inc. at (858) 790-7100. If you have any questions regarding this process, please contact Med***Impact***'s Customer Service at (800) 788-2949.

Member/Provider Information:

MDwise Member's Name:	**Provider's Name:**	
MDwise Member's ID #:	**Provider's Specialty:**	
MDwise Member's DOB (mm-dd-yy):	**Provider's DEA #:**	**Provider's NPI #:**
Pharmacy used by MDwise Member:	**Provider's Telephone Number/Contact Name (xxx-xxx-xxxx):**	
Pharmacy Telephone Number (xxx-xxx-xxxx):	**Provider's Fax Number (xxx-xxx-xxxx):**	

Clinical Information:

Requested Drug: ☐ **Actemra® SC**
NOTE: The IV dosage form of Actemra® is not a covered pharmacy benefit.

Dose and Quantity Requested:

Date Requested: | **Length of Treatment** (please be specific):

Documentation of Medical Necessity (please check all that apply):

1. Does the patient have a diagnosis of **moderate to severe** rheumatoid arthritis? ☐ Yes ☐ No

AND

Is this for initial therapy (i.e., Is the patient naïve to this medication)? ☐ Yes ☐ No

If no, has the patient experienced or maintained ≥20% improvement in tender or swollen joint count while on therapy? ☐ Yes ☐ No

AND

Has this treatment been prescribed by or in consultation with a rheumatologist? ☐ Yes ☐ No

AND

Has the patient tried at least one of the following DMARDs?

methotrexate	☐ Yes	☐ No	*If **yes**, please describe response/reaction to each medication:*
leflunomide	☐ Yes	☐ No	________________
hydroxychloroquine	☐ Yes	☐ No	________________
sulfasalazine	☐ Yes	☐ No	________________

2. Does the patient have a diagnosis of giant cell arteritis? ☐ Yes ☐ No

AND

Is this for initial therapy (i.e., Is the patient naïve to this medication)? ☐ Yes ☐ No

If no, has the patient experienced or maintained symptomatic improvement while on therapy?

☐ Yes ☐ No

Please attach additional information which may indicate why this specific medication is being requested for this patient.