Blue Cross Blue Shield Blue Care Network of Michigan

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Blue Cross Medicare Plus Blue℠ PPO and BCN Advantage℠
Medication Authorization Request Form
Actemra® (tocilizumab) J3262

The most efficient way to request authorization is to use the NovoLogix® system. To access NovoLogix, visit bcbsm.com/providers and log in to Provider Secured Services. Click the link for Medical Prior Authorization. As an alternative, you can use this form to request authorization. Complete this form and fax to 1-866-392-6465. If you have any questions regarding this process, contact the Pharmacy Clinical Help Desk at 1-800-437-3803.

PATIENT INFORMATION	PHYSICIAN INFORMATION
Name	**Name**
ID Number	**Specialty**
Date of birth ☐Male ☐Female	**Address**
Diagnosis (include ICD-10)	**City /State/Zip**
Drug Name	**Phone:** ( ) - **Fax:** ( ) -
Dose and Quantity	**NPI**
Directions	**Contact Person**
Date of Services	**Contact Person's Phone / Ext.**

STEP 1: DISEASE STATE INFORMATION

1. Is this request for self or office administration? ☐ Self-administration ☐ Office-administration
2. Initial or Continuation request for Actemra®? ☐ Initial ☐ Continuation. Date of last dose _____
3. Is the patient being seen by a Rheumatologist? ☐ Yes ☐ No. Provide physician specialty_____
4. What is the patient's diagnosis? ☐ Moderate to Severe Rheumatoid Arthritis ☐ Systemic Juvenile Idiopathic Arthritis (SJIA) ☐ Polyarticular Juvenile Idiopathic Arthritis (PJIA) ☐ Cytokine Release Syndrome associated with CAR-T therapy (prescribed by or in consultation with an oncologist) ☐ Giant Cell Arteritis ☐ Other. Please specify diagnosis_____
5. Has the patient had prior treatment with at least one oral Disease Modifying Anti-Rheumatic Drug (DMARD) (e.g. methotrexate or leflunomide)? ☐ Yes ☐ No
6. Which of the following biologic agents has the patient tried and failed? ☐ Remicade® ☐ Infliximab biosimilar such as Inflectra®, Renflexis® or Avsola™ ☐ Other. Please list. If none, state none_____
7. What is the patient's condition since starting Actemra®? Please check all that apply.
   ☐ Improvement in joint swelling compared to baseline ☐ Improvement in tender joints compared to baseline
   ☐ Improvement in pain compared to baseline ☐ Improvement in activities of daily living compared to baseline
   ☐ Improvement in morning stiffness compared to baseline ☐ Clinically stable ☐ Other. Please specify_____
8. Please attach any chart notes or additional documentation and submit to plan. ***(Required)***

Coverage won't be provided if the prescribing physician's signature and date aren't 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's Signature** **Date**

Step 2: Checklist	☐ Form Completely Filled Out ☐ Attached Chart Notes	☐ Concurrent Medical Problems ☐ Prior Therapies
Step 3: Submit	**Fax the completed form to 1-866-392-6465**	