



**Actemra® (tocilizumab)
Prior Authorization Request Form**

Beneficiary Information

Name: _____
Medicaid ID #: _____ Date of Birth: _____

Billing Provider Information (Pharmacy, Physician, or Facility)

Name: _____ Medicaid ID #: _____
NPI #: _____ Phone #: _____ Fax #: _____
Requested Drug: _____ NDC: _____
Requested Procedure Code (if applicable) _____ Total # of Units Requested (per 6 months) _____

Prescriber Information

Name: _____ Medicaid ID # _____
NPI #: _____ Phone #: _____ Fax #: _____

Requested Information

1. Please indicate the diagnosis and severity for which Actemra is being prescribed (no diagnosis codes):

2. What specialty if the prescriber? Rheumatologist Other (please specify): _____
3. Documentation of inadequate response to one or more DMARDs (for adults only):

4. Lab results:
TB Skin Test Date: _____ TB Skin Test Result: Positive Negative
ANC Date: _____ ANC (cells per mm³): _____
Platelet Count Date: _____ Count (cells per mm³): _____
LFT Date: _____ ALT (IU/L): _____ AST (IU/L): _____

For renewals documentation of appropriate lab testing (neutrophils, platelets, liver function tests, and lipids) will be required.

Prescriber's Signature: _____ **Date:** _____

**The completed form should be faxed to the HP Prior Authorization Unit at 1-800-913-2229.
This form will be returned unprocessed if it is not completed in its entirety.**