Clinical Pharmacy Program Guidelines for Actemra - ARIZONA

<table>
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<tr>
<th>Program</th>
<th>Medication</th>
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<tr>
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<td>Actemra (tocilizumab) subcutaneous</td>
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1. **Background:**

Actemra is indicated for the treatment of adult patients with moderately-to severely-active rheumatoid arthritis who have had an inadequate response to one or more Disease-Modifying Anti-Rheumatic Drugs (DMARDs).

Actemra is also indicated in adult patients with giant cell arteritis.

**Actemra IV is not a pharmacy benefit for the UnitedHealthcare Community Plan**

2. **Coverage Criteria:**

A. **Rheumatoid Arthritis (RA)**

1. **Initial Authorization**

   a. Diagnosis of moderately to severely active RA (eg, swollen, tender joints with limited range of motion)

   -AND-

   b. Prescribed or recommended by a rheumatologist

   -AND-

   c. History of failure, contraindication, or intolerance to one non-biologic disease modifying anti-rheumatic drug (DMARD) [eg, methotrexate, leflunomide, sulfasalazine, hydroxychloroquine]

   -AND-

   d. Patient is not receiving Actemra in combination with any of the following:

      1) Biologic DMARD [eg, Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)]
      2) Janus kinase inhibitor [eg, Xeljanz (tofacitinib)]
      3) Phosphodiesterase 4 (PDE4) inhibitor [e.g. Otezla (apremilast)]
-AND-

e. One of the following:

   (1) History of failure, contraindication, or intolerance to both of the following:

       (a) Humira (adalimumab)
       (b) Enbrel (etanercept)

   -OR-

   (2) For continuation of prior Actemra therapy

Authorization will be issued for 12 months.

2. Reauthorization

   a. Documentation of positive clinical response to Actemra therapy

   -AND-

   b. Patient is not receiving Actemra in combination with any of the following:

       (1) Biologic DMARD [eg, Enbrel (etanercept), Humira (adalimumab),
           Cinzia (certolizumab), Simponi (golimumab)]
       (2) Janus kinase inhibitor [eg, Xeljanz (tofacitinib)]
       (3) Phosphodiesterase 4 (PDE4) inhibitor [e.g., Otezla (apremilast)]

Authorization will be issued for 12 months.

B. Giant Cell Arteritis

1. Initial Authorization

   a. Diagnosis of giant cell arteritis

   -AND-

   b. Prescribed or recommended by a rheumatologist

   -AND-
c. History of failure, contraindication, or intolerance to one glucocorticoid (e.g., prednisone)

-AND-

d. Patient is not receiving Actemra in combination with any of the following:

(1) Biologic DMARD [eg, Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)]
(2) Janus kinase inhibitor [eg, Xeljanz (tofacitinib)]
(3) Phosphodiesterase 4 (PDE4) inhibitor [e.g. Otezla (apremilast)]

Authorization will be issued for 12 months.

2. Reauthorization

a. Documentation of positive clinical response to Actemra therapy

-AND-

b. Patient is not receiving Actemra in combination with any of the following:

(1) Biologic DMARD [eg, Enbrel (etanercept), Humira (adalimumab), Cimzia (certolizumab), Simponi (golimumab)]
(2) Janus kinase inhibitor [eg, Xeljanz (tofacitinib)]
(3) Phosphodiesterase 4 (PDE4) inhibitor [e.g. Otezla (apremilast)]

Authorization will be issued for 12 months.

3. References:


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<thead>
<tr>
<th>Program</th>
<th>Program type – Prior Authorization</th>
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<tbody>
<tr>
<td><strong>Change Control</strong></td>
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<tr>
<td><strong>Date</strong></td>
<td>Change</td>
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<tr>
<td>August 2017</td>
<td>New policy specific to Arizona.</td>
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<tr>
<td>October 2017</td>
<td>Added review criteria for giant cell arteritis. Updated background and references.</td>
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