Clinical Pharmacy Program Guidelines for Actemra

<table>
<thead>
<tr>
<th>Program</th>
<th>Prior Authorization</th>
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<tbody>
<tr>
<td>Medication</td>
<td>Actemra (tocilizumab) subcutaneous</td>
</tr>
<tr>
<td>Issue Date</td>
<td>2/2015</td>
</tr>
<tr>
<td>Pharmacy and Therapeutics Approval Date</td>
<td>3/2017</td>
</tr>
<tr>
<td>Effective Date</td>
<td>5/2017</td>
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1. **Background:**

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 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]

      -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 all of the following:

   (a) Cimzia (certolizumab)
   (b) Humira (adalimumab)
   (c) 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), 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:**


<table>
<thead>
<tr>
<th>Date</th>
<th>Change</th>
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<tbody>
<tr>
<td>February 2015</td>
<td>New policy</td>
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</table>
| March 2016        | Initial therapy section: Added Enbrel to list of preferred drugs that require history of failure, contraindication, or intolerance  
|                   | Added technician note indicating Actemra as a non-preferred drug and listing the preferred alternatives                                   
|                   | Annual Review- Updated policy template                                                                                               |
| October 2016      | Annual Review – no change                                                                                                             |
| March 2017        | Updated “Community & State” to “Community Plan” in background. Added Otezla to list of medications not to be used with Actemra           
|                   | Updated policy template.                                                                                                              |