Pharmacy Drug Policy Checklist

POLICY NAME	Tocilizumab Products - Pharmacy benefit	POLICY #	

Criteria

Exclusion Criteria – Any of the following prevents coverage

- ☐ **6.1** Inadequate response to initial or previous tocilizumab therapy
- ☐ **6.2** Health Alliance does not cover concurrent therapy with other immunomodulators based upon the possible increased risk for infections and other potential pharmacological interactions

Coverage Criteria for Rheumatoid Arthritis (RA)

- ☐ **1.1** See Rheumatoid Arthritis Immunomodulator Therapies policy

Coverage Criteria for Polyarticular Juvenile Idiopathic Arthritis (PJIA)

- ☐ **2.1** See Polyarticular Juvenile Idiopathic Arthritis Immunomodulator Therapies policy

Coverage Criteria for Systemic Juvenile Idiopathic Arthritis (SJIA)

- ☐ **3.1** Diagnosis of Systemic Juvenile Idiopathic Arthritis (SilA)
- ☐ **3.2** Ordered by a Rheumatologist (musculoskeletal doctor)
- ☐ **3.3** Documentation to support ONE of the following:
  - Documented trial and failure of one non-steroidal anti-inflammatory drug (NSAID, such as ibuprofen or naproxen) for at least 2 weeks
  - Documentation the patient has moderate-to-severe disease including any one of the following systemic manifestations:
  - Fever
  - Serositis
  - Early Macrophage Activation Syndrome (MAS)

Coverage Criteria for Giant Cell Arteritis

- ☐ **4.1** Diagnosis of Giant Cell Arteritis
- ☐ **4.2** Ordered by a Rheumatologist (musculoskeletal doctor), Ophthalmologist (eye doctor), or Neuro- Ophthalmologist (doctor of the eyes and nervous system)
- ☐ **4.3** Documented failure to respond to a minimum 3-month trial of glucocorticoids
- ☐ **4.4** Documented failure to respond to a minimum 3-month trial, intolerance, or contraindication to Rinvoq

Coverage Criteria for Systemic Sclerosis-Associated Interstitial Lung Disease (SSc-ILD)

- ☐ **5.1** Diagnosis of Systemic Sclerosis-Associated Interstitial Lung Disease (SSc-ILD)
- ☐ **5.2** Age 18 years or older
- ☐ **5.3** Ordered by or in consultation with a pulmonologist (lung doctor) or rheumatologist (musculoskeletal doctor)
- ☐ **5.4** Documented trial and subsequent failure or contraindication to mycophenolate mofetil or cyclophosphamide
- ☐ **5.5** Only subcutaneous, not IV, Actemra will be used for this indication
- ☐ **5.6** Medication will not be used in combination with Ofev
- ☐ **5.7** Medication will not be used in combination with other immunomodulators