### Actemra (tocilizumab)
**Effective January 1, 2020**

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<tr>
<th>Plan</th>
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<th>☒ Commercial/Exchange</th>
<th>Program Type</th>
<th>☒ Prior Authorization</th>
<th>☐ Quantity Limit</th>
<th>☐ Step Therapy</th>
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<td>Benefit</td>
<td>☒ Pharmacy Benefit</td>
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<td>Specialty Limitations</td>
<td>This medication has been designated specialty and must be filled at a contracted specialty pharmacy.</td>
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#### Specialty Medications
- **All Plans**
  - Phone: 866-814-5506
  - Fax: 866-249-6155

#### Non-Specialty Medications
- **MassHealth**
  - Phone: 877-433-7643
  - Fax: 866-255-7569
- **Commercial**
  - Phone: 800-294-5979
  - Fax: 888-836-0730
- **Exchange**
  - Phone: 855-582-2022
  - Fax: 855-245-2134

#### Medical Specialty Medications (NLX)
- **All Plans**
  - Phone: 844-345-2803
  - Fax: 844-851-0882

#### Exceptions
- N/A

### Overview
Actemra is an interleukin-6 (IL-6) receptor antagonist. Endogenous IL-6 is induced by inflammatory stimuli and mediates a variety of immunological responses. Inhibition of IL-6 receptors by Actemra leads to a reduction in cytokine and acute phase reactant production.

### Coverage Guidelines
**Moderately to severely active rheumatoid arthritis (RA)**
1. Authorization may be granted for members who are currently receiving treatment with Actemra, excluding when the product is obtained as samples or via manufacturer’s patient assistance programs
   **OR**
2. Authorization may be granted for treatment of moderately to severely active RA when one of the following criteria is met:
   a. The member has experienced an inadequate response or intolerance to all preferred products (Enbrel, Humira and Rinvoq)
   b. The member has a contraindication to all preferred products (Enbrel, Humira and Rinvoq) and meets one of the following:
      - The member has experienced an inadequate response to at least a 3-month trial of methotrexate despite adequate dosing (i.e., titrated to 20 mg/week).
      - The member has an intolerance or contraindication to methotrexate (see Appendix).

**Active Polyarticular Juvenile Idiopathic Arthritis (pJIA)**
Authorization may be granted for members who have previously received Actemra or Orencia excluding when these products have been obtained via physician samples or patient assistant program
   **OR**

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1. Authorization may be granted for treatment of active pJIA when BOTH of the following criteria is met:
   a. One of the following:
      ▪ The member experienced an inadequate response to BOTH methotrexate AND an NSAID.
      ▪ The member has experienced an intolerance or has a contraindication to BOTH methotrexate and NSAIDs. (see Appendix A)
   AND
   b. One of the following:
      ▪ The member has experienced an inadequate response to at least TWO TNF inhibitors (e.g., Enbrel, Humira, or Remicade). A 3-month trial for each is required
      ▪ The member has experienced an intolerance or has a contraindication to TNF inhibitors.

Active Systemic Juvenile Idiopathic Arthritis (sJIA)
1. Authorization may be granted for members who have previously received Actemra or Kineret excluding when these products have been obtained via physician samples or patient assistant program.
   OR
2. Authorization of 24 months may be granted for treatment of active sJIA when any TWO of the following criteria are met:
   a. The member has an inadequate response to at least a 2-week trial of corticosteroids.
   b. The member has an inadequate response to at least a 3-month trial of methotrexate
   c. The member has an inadequate response to at least a 3-month trial with NSAIDs

Giant Cell Arteritis
Authorization may be granted for members diagnosed with Giant Cell Arteritis

Unicentric and Multicentric Castleman’s Disease
Authorization may be granted for members diagnosed with of Unicentric or Multicentric Castleman’s disease.

Cytokine Release Syndrome (CRS)- (Intravenous Use ONLY)
Authorization be granted for treatment of severe or life-threatening chimeric antigen receptor T cell-induced cytokine release syndrome when documentation of diagnosis is submitted.

Continuation of Therapy
1. Reauthorizations for all diagnoses, excluding CRS, will be granted when documented is submitted supporting improvement in member’s condition
2. Reauthorization for CRS will not be granted

Limitations
1. Initial approvals for all diagnoses will be granted for 24 months, excluding CRS.
2. Initial approvals for CRS will be granted for a total of 4 doses.
3. For all indications: Member has a pretreatment tuberculosis (TB) screening with a TB skin test or an interferon gamma release assay (e.g., QFT-GIT, T-SPOT.TB).
   a. Note: Members who have received Actemra or any other biologic DMARD or targeted synthetic DMARD (e.g., Xeljanz) are exempt from requirements related to TB screening in this Policy.
Appendix
Examples of Contraindications to Methotrexate
1. Alcoholism, alcoholic liver disease or other chronic liver disease
2. Breastfeeding
3. Blood dyscrasias (e.g., thrombocytopenia, leukopenia, significant anemia)
4. Elevated liver transaminases
5. History of intolerance or adverse event
6. Hypersensitivity
7. Interstitial pneumonitis or clinically significant pulmonary fibrosis
8. Myelodysplasia
9. Pregnancy or planning pregnancy (male or female)
10. Renal impairment
11. Significant drug interaction

References
1. Actemra (tocilizumab) [prescribing information]. South San Francisco, CA: Genentech Inc; June 2019
11/20/19 – Added Rinvoq as a trial for RA and Skyrizi for PS. Added started and stabilized criteria. Approval duration switched to 4 doses.

Disclaimer
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