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Kaiser Foundation Health Plan of Washington Options, Inc.
Provider Communications, RCR-A3W-04
PO Box 34262, Seattle WA 98124-1262

AUGUST 28, 2024

UPDATED PRIOR AUTHORIZATION CRITERIA FOR TOCILIZUMAB (ACTEMRA)

Dear Provider,

Tocilizumab (Actemra) is on the **non-Medicare** list of office-administered drugs requiring prior authorization. **Effective December 1, 2024,** the criteria for intravenous tocilizumab (Actemra) will be updated to reflect the preferred biosimilar, tocilizumab-aazg (Tyenne). This change does not affect current authorizations for Actemra; however, any new authorizations are subject to the criteria below. **This letter is a notification of the change in prior authorization criteria required before administering this medication under the medical benefit.**

Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington, Options, Inc.(Kaiser Permanente) require prior authorization for a select group of injectable drugs that may be administered under the medical benefit in a physician's office or by home infusion. These reviews are intended to ensure consistent benefit adjudication as well as appropriate utilization in accordance with the Kaiser Permanente Pharmacy & Therapeutics Committee's evidence-based criteria for coverage.

Prior Authorization Criteria for Intravenous Tocilizumab (Actemra) (changes are in bold):

DRUG NAME	COVERAGE CRITERIA
Tocilizumab intravenous	Covered for new starts who have a failure, contraindication, or intolerance to the preferred biosimilar tocilizumab-aazg (Tyenne) AND one of the below: • Covered for adult patients ≥ 18 years old with thyroid eye disease (TED) who meet the following criteria: o Confirmed diagnosis of active TED by an oculoplastic surgeon o Clinical Activity Score (CAS) ≥4 (on the 7-item scale) o Moderate-to-severe active TED (not sight-threatening but has appreciable impact on daily life), associated with at least one of the following: ▪ Lid retraction ≥2 mm ▪ Moderate or severe soft tissue involvement ▪ Exophthalmos ≥3 mm above normal for race and gender ▪ Intermittent or constant diplopia o Inadequate response, intolerance, or contraindication to IV steroid therapy with or without radiation therapy. • Covered for patients with neuromyelitis optica spectrum disorder (NMOSD) who meet the following criteria: o Prescribed by or in consultation with a Multiple sclerosis specialist or Neurologist o Age ≥18 years o AQP4 antibody seropositive • Covered for cytokine release syndrome due to chimeric antigen receptor-T (CAR-T) therapy.

DRUG NAME	COVERAGE CRITERIA
	• Covered for patients ≥ 2 years old with systemic subtype juvenile idiopathic arthritis who have failure, contraindication, or intolerance to NSAIDs, glucocorticoids, and anakinra. • Covered for patients ≥ 2 years old with polyarticular juvenile idiopathic arthritis (JIA) who have had failure, contraindication, or intolerance to methotrexate. **Established patients on Actemra must have a documented inadequate response or intolerance to a tocilizumab biosimilar (e.g., Tyenne)** Not covered for use in combination with disease-modifying or other biological therapies including (but not limited to): • infliximab, adalimumab, etanercept, vedolizumab, rituximab, abatacept, certolizumab, golimumab, ustekinumab, canakinumab, tofacitinib, upadacitinib, ozanimod, apremilast Not covered under the medical benefit for other indications (hospital, clinic, or home infusion). • Note: may be covered under the pharmacy benefit Quantity Limit: • TED and NMOSD: 800 mg every 4 weeks

Additional Information

A complete list of office-administered injectable drugs requiring prior authorization can be found on the Kaiser Permanente provider website at https://wa-provider.kaiserpermanente.org/provider-manual/clinical-review/officeinject.

To request prior authorization review, please use the Referral Request online form (login required) located on the Kaiser Permanente provider website at https://wa-provider.kaiserpermanente.org/provider-manual/clinical-review/preservice.

You can also fax your request to the Review Services department toll-free at 1-888-282-2685.

Thank you for the care you provide to our members, your patients. If you have any questions about this process, please call Review Services at 1-800-289-1363, Monday through Friday from 8 a.m. to 5 p.m.

Sincerely,

Ravi Ubriani, MD, Chair
Pharmacy & Therapeutics Committee