

OPTIMA FAMILY CARE MEDALLION 4.0

PHARMACY/MEDICAL PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-844-723-2094. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete form will delay authorization process.

Drug Requested: (check one below):

SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (sJIA)

Actemra® (tocilizumab) (J3262)

ILARIS® (canakinumab) (J0638)

DRUG INFORMATION: Complete information below. If incomplete, authorization process will be delayed.

Drug Name/Form: _____ Strength/Month: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code: _____

- **Recommended Actemra® dosage every 2 weeks:** <30kg dose of 12mg per kg or >30kg dose of 8mg per kg
- **Recommended Ilaris® dosage every 4 weeks SQ:** 4mg/kg (with a maximum of 300mg) ≥ 7.5kg

Medication can only be provided by the Physician's office.*

CLINICAL CRITERIA: Complete information below. To qualify, **ALL** appropriate boxes **must** be checked.

Medical notes MUST be submitted to support lab values and diagnosis.

First approval would be for 3 months; Continuation of therapy, please refax form with documentation of CRP or ESR along with progress notes to document therapy effective.

Patients age 2 years- 17years YES **OR** NO

Persistent sJIA activity for a minimum of six months: Date of diagnosis _____

Trial and Failure of NSAIDs and corticosteroids for >3months: (history of claims will be reviewed) YES **OR** NO

≥ 5 active joint with fever for at least 2 weeks YES **OR** NO

OR

≥ 2 active joint with fever for at least 5 days and taking prednisone or equivalent 0.5 mg/kg/day or 30mg/day YES **OR** NO

CRP >15 mg/L YES **OR** NO

OR

High ESR >45 mm/hr. YES **OR** NO

Fever >38°C or 100.4°F for at least two (2) weeks YES **OR** NO

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____