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 the authorization process.***

Drug Requested: Actemra® (tocilizumab)-***Cytokine Release Syndrome (CRS)*** **(J-3262)** ***(Medical)***

DRUG INFORMATION: Complete all information below or authorization process will be delayed.

Drug Form/Strength/Quantity: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ ***ICD Code, if applicable*:** _____

Recommended dose for treatment of CRS given as a 60-minute intravenous infusion:

Patients less than 30 kg weight: 12mg per kg
Patients at or above 30 kg weight: 8 mg per kg

Doses exceeding 800 mg per infusion are NOT recommended in CRS patients.

Subcutaneous administration is NOT approved for CRS.

CLINICAL CRITERIA: If clinical improvement does NOT occur after the first dose, up to 3 additional doses may be administered (with at least an 8-hour interval between consecutive doses). Tocilizumab may be administered as monotherapy or in combination with corticosteroids.

- Has member been approved by their insurance for chimeric antigen receptor (CAR) T cell therapy? ❑ YES ❑ NO

APPROVAL WILL BE FOR FOUR (4) DOSES.

Medication being provided by (check applicable box below):

❑ **Location/site of drug administration:** _____

NPI or DEA # of administering location: _____

OR

❑ **Specialty Pharmacy - PropriumRx**

*****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 #: _____

REVISED/UPDATED: 7/1/2018