

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 1-800-750-9692. 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)-*Giant Cell Arteritis (GCA) (self-administered) (J-3590).*

DRUG INFORMATION: Complete below. Incomplete information will delay the authorization process.

Drug Form/Strength/Quantity: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

Recommended Dose: 162 mg given once every week (in combination with a tapering course of glucocorticoids)

CLINICAL CRITERIA: Check applicable boxes below. All criteria **must** be met and documented with submission of labs and chart notes dated **within 60 days** for approval to qualify. If incomplete, authorization will be delayed.

- **Must be prescribed by or in consultation with (check applicable box below):**

<input type="checkbox"/> Neurologist	<input type="checkbox"/> Rheumatologist	<input type="checkbox"/> Ophthalmologist
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- Member has diagnosis of Giant Cell Arteritis (GCA)

AND

- Member is at least 50 years of age

AND

- Member has ESR >30mm/hour **OR** CRP > 1 mg/dL currently on prednisone

AND

- Member has had trial and failure of **ONE** of the following:

- 40mg Prednisolone daily for 4 weeks
- 80mg Prednisolone daily if eye symptoms for 4 weeks

OR

- Member has a contraindication to prednisolone and documentation that GI BLEED has occurred within the last 30 days has been submitted (**medical chart notes must be attached**) **AND** member has one of the following (**labs must be submitted**):

- ESR >50mm/hour **NOT** currently on prednisolone

OR

- CRP > 2.49 mg/dL **NOT** currently on prednisolone

AND

MEDICAL CHART NOTES DOCUMENTING THE FOLLOWING MUST BE SUBMITTED:

- Unequivocal cranial symptoms of GCA new-onset - at least **TWO** of the following features **must** be present:
 - localized headache, scalp tenderness, temporal artery tenderness, decrease pulsation, ischemia-related vision loss, or otherwise unexplained mouth or jaw pain upon mastication

AND

AT LEAST ONE OF THE FOLLOWING MUST BE SUBMITTED FOR DOCUMENTATION:

- Temporal artery biopsy revealing features of GCA **must** be submitted documenting at least **TWO (2)** of the following:

(continued on next page)

<input type="checkbox"/> Granulomatous inflammation of the blood vessel wall	<input type="checkbox"/> Disruption and fragmentation of internal elastic lamina	<input type="checkbox"/> Giant cells
<input type="checkbox"/> Proliferation of the intima with associated occlusion of the lumen	<input type="checkbox"/> The healed stage reveals collagenous thickening of the vessel wall and the artery is transformed into a fibrous cord	

OR

- Magnetic resonance angiography (MRA), Computed tomography angiography (CTA), or Positron emission tomography-computed tomography angiography (PET-CTA) ***must*** be submitted to document the following:
 - Evidence of large-vessel vasculitis by angiography or cross-sectional imaging study

Medication being provided by (check applicable box below):

- Physician's Office **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: 7/5/2018**