OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

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 1-844-348-3720**. 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**.

SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (sJIA)

Drug Requested: ILARIS® (canakinumab) **(J0638) (Medical) (Non-Preferred)**

DRUG INFORMATON: Complete information below or authorization will be delayed.

Drug Form/Strength: _____

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

Diagnosis: _____ **ICD Code:** _____

Recommended 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: To qualify, **ALL** appropriate boxes **must** be checked to ensure authorization will **NOT** be delayed. Medical notes **MUST** be submitted to support lab values and diagnosis.

Initial approval: 3 months. For continued 12-month approval, please refax form with documentation of CRP or ESR along with progress notes to document therapy effective. Chart notes and labs MUST be submitted along with request for documentation of criteria.

- ❑ Patients must be aged 2 years - 17years
- ❑ Patient must have had persistent sJIA activity for a minimum of six (6) months

  Date of diagnosis must be noted _____

  - ❑ Patient must have trial and failure of NSAIDs and corticosteroids for > 3 months consecutively within the last 4 months **(paid claims will be reviewed for verification)**

    AND

  - ❑ Patient must have had ≥ 5 active joints with concomitant fever for at least 2 weeks within the last 3 months of this request

    OR

  - ❑ Patient must have had ≥ 2 active joints with concomitant fever for at least 5 days and trial of prednisone or equivalent dosed at 0.5mg/kg/day or 30mg/day within the last 3 months of this request

    AND

(continued on next page)

- ❑ Patient must have had CRP (>15 mg/L) within the last 2 months of this year **(submit lab for documentation)**

AND

- ❑ Patient must have had ESR (>45mm/hr) within the last 2 months of this year **(submit lab for documentation)**

AND

- ❑ Patient must have had fever > 38º C or 100.4º F for at least 2 weeks within the last 2 months of this request

AND

- ❑ Patient must have documented failure of Actemra® **(failure is defined as paid claims of Actemra® for at least 6 months AND lab values above did not respond to the preferred drug)**

OR

- ❑ Patient has history of anaphylactic reaction to Actemra® **(anaphylaxis is defined as an emergency department (ER/ED) visit due to throat or tongue swelling and/or shortness of breath) or** development of skin reactions that lead to Stevens Johnson syndrome.

  Progress notes and labs documenting anaphylactic reaction or development of SJS MUST be submitted.

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 #: _____

*** Approved by Pharmacy and Therapeutics Committee**: 6/21/2018
REVISED/UPDATED: 10/1/2018