

OPTIMA HEALTH COMMUNITY 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 INFORMATION: 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 > 38° C or 100.4° 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 (Reformatted) 2/5/2019