OPTIMA HEALTH 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 1-844-723-2094**. 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 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**

(Continued on next page; signature page MUST be attached to this request.)

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*****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: ~~4/6/2018; 5/25/2018; 8/14/2018; 10/8/2018;~~ **(Reformatted) 2/4/2019**