

**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 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