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 1-800-750-9692**. 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 or authorization will be delayed.

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

❑ **Neurologist**	❑ **Rheumatologist**	❑ **Ophthalmologist**

❑ 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

(continued on next page)

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:

❑ Granulomatous inflammation of the blood vessel wall	❑ Disruption and fragmentation of internal elastic lamina	❑ Giant cells
❑ Proliferation of the intima with associated occlusion of the lumen	❑ 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 #: _____

***Approved by Pharmacy and Therapeutics Committee**: 7/20/2017
REVISED/UPDATED: ~~9/27/2017; 1/19/2018; 3/31/2018;~~ **8/14/2018**