

# 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 the authorization process.**

**Drug Requested:** Actemra® (tocilizumab) (IV INFUSION ONLY) (**J-3262**) (**Medical**).

**DRUG INFORMATION:** Complete all information below or authorization will be delayed.

**Drug Form/Strength:** \_\_\_\_\_

**Dosing Schedule:** \_\_\_\_\_ **Length of Therapy:** \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_ **ICD Code:** \_\_\_\_\_

**CLINICAL CRITERIA:** Information below **must** be completed to ensure authorization will **NOT** be delayed.

**DIAGNOSIS: Rheumatoid Arthritis (RA)** – all boxes that apply **must** be checked to qualify.

- Prescriber is a Rheumatologist
- Patient has tried and failed **at least one (1)** previous **DMARD** therapy including but not limited to: (**check each that have been tried**)

<input type="checkbox"/> methotrexate	<input type="checkbox"/> sulfasalazine
<input type="checkbox"/> azathioprine	<input type="checkbox"/> leflunomide
<input type="checkbox"/> auranofin	<input type="checkbox"/> hydroxychloroquine
<input type="checkbox"/> Other: _____	

Patient has tried and failed **two (2)** of the following:

- Cimzia™
  - Remicade®
- OR**
- Simponi® ARIA™

(Cimzia™, Remicade®, and Simponi® ARIA™ require prior authorization. Forms can be found at [www.Optimahealth.com](http://www.Optimahealth.com))

**DIAGNOSIS: Systemic Juvenile Idiopathic Arthritis (sJIA)** – all boxes that apply **must** be checked to qualify.

- Prescriber is a Rheumatologist
- Patient must be aged 2 years- 17years
- Patient must have persistent sJIA activity for a minimum of six months. Date of diagnosis: \_\_\_\_\_

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- Trial and failure of NSAIDs and corticosteroids for >3 months (history of claims will be reviewed)
- ≥5 active joints with fever for at least 2 weeks **OR**
- ≥2 active joints with fever for at least 5 days and taking prednisone or equivalent 0.5mg/kg/day or 30mg/day
- CRP >15mg/L **OR**
- High ESR >45mm/hr
- Fever >38° C or 100.4° F for at least two (2) weeks

**Medication being provided by - check applicable box(es) below.**

- Location/site of drug administration: \_\_\_\_\_  
NPI or DEA # of administering location: \_\_\_\_\_

**OR**

- 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: 6/17/2010**

**REVISED/UPDATED:** 6/2/2011; 8/11/2011; 9/14/2011; 4/17/2012; 10/1/2012; 1/16/2014; 2/6/2014; 4/28/2014; 5/22/2014; 6/30/2014; 8/8/2014; 10/1/2014; 10/31/2014; 11/21/2014; 4/2/2015; 5/23/2015; 1/29/2016; 3/30/2016; 9/22/2016; 12/28/2016; 1/3/2017; 8/1/2017; 5/18/2018; **10/12/2018**