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) (**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)**

❑ methotrexate	❑ sulfasalazine
❑ azathioprine	❑ leflunomide
❑ auranofin	❑ hydroxychloroquine
❑ Other: _____	

- ❑ **Patient has tried and failed two (2) of the following:**
  - ❑ Cimzia™
  - ❑ Renflexis®
  - ❑ Simponi® ARIA™

(Cimzia™, Renflexis®, and Simponi® ARIA™ require prior authorization. Forms can be found at 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 >38º C or 100.4º 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;~~ **(Reformatted) 2/4/2019**