

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) (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[™], 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: _____

(continued on next page)

- 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; (Reformatted) 2/4/2019.