OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

PHARMACY 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 authorization process.**

Drug Requested: Actemra® SQ (tocilizumab) **(self-administered) (Pharmacy) (Non-Preferred)**

DRUG INFORMATION: Complete information below or authorization process will be delayed

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code, if applicable:** _____

CLINICAL CRITERIA: **ALL** boxes **MUST** be checked to qualify to ensure authorization will **NOT** be delayed..

DIAGNOSIS: Rheumatoid Arthritis (RA) –boxes **MUST** be checked to qualify for approval of drug.

- ❑ Prescriber is a Rheumatologist; **AND**
- ❑ Patient has moderate to severe rheumatoid arthritis; **AND**
- ❑ Tried and failed methotrexate; **OR**
- ❑ Requested medication will be used in conjunction with methotrexate; **OR**
- ❑ Patient has a contraindication to methotrexate (e.g., alcohol abuse, cirrhosis, chronic liver disease, or other contraindication)

AND

- ❑ Tried and failed at least **one DMARD** other than methotrexate and (**check each tried)**

❑ sulfasalazine	❑ azathioprine	❑ leflunomide
❑ auranofin	❑ hydroxychloroquine	❑ gold salts
❑ d-penicillamine	❑ cyclosporine	❑ cyclophosphamide
❑ tacrolimus	❑ Other: _____	

AND

- ❑ Trial and failure of **ONE (1)** of the **PREFERRED** biologics below:

❑ **Humira®**	❑ **Enbrel®**

(continued on next page)

DIAGNOSIS: Polyarticular Juvenile Idiopathic Arthritis (PJIA) –boxes **MUST** be checked to qualify.

- ❑ Prescriber is a Rheumatologist; **AND**
- ❑ Patient must be 2 – 17 years of age; **AND**
- ❑ Tried and failed methotrexate; **OR**
- ❑ Requested medication will be used in conjunction with methotrexate; **OR**
- ❑ Patient has a contraindication to methotrexate (e.g., alcohol abuse, cirrhosis, chronic liver disease, or other contraindication)

AND

- ❑ Trial and failure of at least **ONE (1) DMARD** therapy **and (check each tried)**

❑ sulfasalazine	❑ azathioprine	❑ leflunomide
❑ auranofin	❑ hydroxychloroquine	❑ gold salts
❑ d-penicillamine	❑ cyclosporine	❑ cyclophosphamide
❑ tacrolimus	❑ Other: _____	

DIAGNOSIS: Systemic Juvenile Idiopathic Arthritis (SJIA) –boxes **MUST** be checked to qualify.

- ❑ Prescriber is a Rheumatologist; **AND**
- ❑ Patient must be 2 – 17 years of age; **AND**
- ❑ Tried and failed methotrexate; **OR**
- ❑ Requested medication will be used in conjunction with methotrexate; **OR**
- ❑ Patient has a contraindication to methotrexate (e.g., alcohol abuse, cirrhosis, chronic liver disease, or other contraindication)

AND

- ❑ Trial and failure of at least **ONE (1) DMARD** therapy **and (check each tried)**

❑ sulfasalazine	❑ azathioprine	❑ leflunomide
❑ auranofin	❑ hydroxychloroquine	❑ gold salts
❑ d-penicillamine	❑ cyclosporine	❑ cyclophosphamide
❑ tacrolimus	❑ Other: _____	

Medication being provided by (check applicable box below):

❑ **Physician's office** **OR** ❑ **Specialty Pharmacy – PropriumRx**

(Continued on next page; signature page MUST be attached to this request.)

(Signature page MUST be included with request form.)

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: 12/9/2018**