OPTIMA HEALTH COMMUNITY CARE

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 authorization process.***

Drug Requested: ***(check one below)*:**

SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (sJIA)

❑ **Actemra®** (tocilizumab) **(J3262)**	❑ **ILARIS®** (canakinumab) **(J0638)**

DRUG INFORMATON: Complete information below. If incomplete, authorization process will be delayed.

Drug Name/Form: _____ **Strength/Month:** _____

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

Diagnosis: _____ **ICD Code:** _____

- ***Recommended Actemra® dosage every 2 weeks: <30kg dose of 12mg per kg or >30kg dose of 8mg per kg***
- ***Recommended Ilaris® dosage every 4 weeks SQ: 4mg/kg (with a maximum of 300mg) ≥ 7.5kg***

Medication can only be provided by the Physician's office.*

CLINICAL CRITERIA: Complete information below. To qualify, ALL appropriate boxes must be checked. Medical notes MUST be submitted to support lab values and diagnosis.

First approval would be for 3 months; Continuation of therapy, please refax form with documentation of CRP or ESR along with progress notes to document therapy effective.

- ❑ Patients age 2 years- 17years ❑ YES **OR** ❑ NO
- ❑ Persistent sJIA activity for a minimum of six months: Date of diagnosis_____
  - ❑ Trial and Failure of NSAIDs and corticosteroids for >3months: (history of claims will be reviewed) ❑ YES **OR** ❑ NO
  - ❑ ≥ 5 active joint with fever for at least 2 weeks ❑ YES **OR** ❑ NO

    OR
  - ❑ ≥ 2 active joint with fever for at least 5 days and taking prednisone or equivalent 0.5 mg/kg/day or 30mg/day ❑ YES **OR** ❑ NO
  - ❑ CRP >15 mg/L ❑ YES **OR** ❑ NO

    OR
  - ❑ High ESR >45 mm/hr. ❑ YES **OR** ❑ NO
  - ❑ Fever >38ºC or 100.4ºF for at least two (2) weeks ❑ YES **OR** ❑ NO

*****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: ~~8/1/2017;~~ **8/31/2017**;