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 1-800-319-5003. 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)-***Giant Cell Arteritis (GCA)*** ***(self-administered)*** **(J-3590)**.

DRUG INFORMATION: Complete below. Incomplete information will delay the authorization process.

Drug Form/Strength/Quantity: _____

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

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

Recommended Dose: 162 mg given once every week (in combination with a tapering course of glucocorticoids)

CLINICAL CRITERIA: Check applicable boxes below. All criteria must be met and documented with submission of labs and chart notes dated within 60 days for approval to qualify. If incomplete, authorization will be delayed.

- **Must be prescribed by or in consultation with** ***(check applicable box below)*****:**

❑ **Neurologist**	❑ **Rheumatologist**	❑ **Ophthalmologist**

❑ Member has diagnosis of Giant Cell Arteritis (GCA)

AND

❑ Member is at least 50 years of age

AND

❑ Member has ESR >30mm/hour **OR** CRP> 1 mg/dL currently on prednisone

AND

❑ Member has had trial and failure of ***ONE*** of the following:

- 40mg Prednisolone daily for 4 weeks
- 80mg Prednisolone daily if eye symptoms for 4 weeks

OR

❑ Member has a contraindication to prednisolone and documentation that GI BLEED has occurred within the last 30 days has been submitted ***(medical chart notes must be attached)*** **AND** member has one of the following ***(labs must be submitted)***:

- ESR >50mm/hour ***NOT*** currently on prednisolone

OR

- CRP> 2.49 mg/dL ***NOT*** currently on prednisolone

AND

MEDICAL CHART NOTES DOCUMENTING THE FOLLOWING MUST BE SUBMITTED:

- Unequivocal cranial symptoms of GCA new-onset - at least ***TWO*** of the following features ***must*** be present:
  - localized headache, scalp tenderness, temporal artery tenderness, decrease pulsation, ischemia-related vision loss, or otherwise unexplained mouth or jaw pain upon mastication

AND

AT LEAST ONE OF THE FOLLOWING MUST BE SUBMITTED FOR DOCUMENTATION:

- Temporal artery biopsy revealing features of GCA ***must*** be submitted documenting at least ***TWO (2)*** of the following:

(continued on next page)

❑ Granulomatous inflammation of the blood vessel wall	❑ Disruption and fragmentation of internal elastic lamina	❑ Giant cells
❑ Proliferation of the intima with associated occlusion of the lumen	❑ The healed stage reveals collagenous thickening of the vessel wall and the artery is transformed into a fibrous cord	

OR

- Magnetic resonance angiography (MRA), Computed tomography angiography (CTA), or Positron emission tomography-computed tomography angiography (PET-CTA) ***must*** be submitted to document the following:
  - Evidence of large-vessel vasculitis by angiography or cross-sectional imaging study

Medication being provided by (check applicable box below):

❑ **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**: 7/20/2017
REVISED/UPDATED: ~~9/27/2017;~~ ~~1/19/2018;~~ **3/31/2018**