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 the authorization process.***

Drug Requested: **Actemra®** (tocilizumab) (**IV INFUSION ONLY**) (**J-3262**) ***(Medical)***.

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

Drug Form/Strength/Month: _____

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

Diagnosis: _____ **ICD Code:** _____

CLINICAL CRITERIA: Check all that apply. Applicable boxes must be checked to qualify. Incomplete data will delay the authorization process.

- ❑ 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
  - ❑ azathioprine
  - ❑ auranofin
  - ❑ hydroxychloroquine
  - ❑ sulfasalazine
  - ❑ leflunomide
  - ❑ Other: _____
- ❑ **Patient has tried and failed *two (2)* of the following**:
  - ❑ Cimzia™
  - ❑ Remicade®

  OR

  - ❑ Simponi® ARIA™

(Cimzia™, Remicade®, and Simponi® ARIA™ require prior authorization. Forms can be found at www.Optimahealth.com)

Medication being provided by: ***(Please check applicable box below.)***

- ❑ **Location/site of drug administration:** _____

  NPI or DEA # of administering location: _____

  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 #: _____

REVISED/UPDATED: ~~8/1/2017; 8/28/2017;~~ **5/25/2018**