

# OPTIMA HEALTH PLAN

## 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 1-844-202-5034. 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)-*Cytokine Release Syndrome (CRS) (J-3262) (Medical)*

**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 for treatment of CRS given as a 60-minute intravenous infusion:**

Patients less than 30 kg weight: 12mg per kg

Patients at or above 30 kg weight: 8 mg per kg

Doses exceeding 800 mg per infusion are **NOT** recommended in CRS patients.

Subcutaneous administration is **NOT** approved for CRS.

**CLINICAL CRITERIA:** If clinical improvement does NOT occur after the first dose, up to 3 additional doses may be administered (with at least an 8-hour interval between consecutive doses). Tocilizumab may be administered as monotherapy or in combination with corticosteroids.

- Has member been approved by their insurance for chimeric antigen receptor (CAR) T cell therapy?  YES  NO

**APPROVAL WILL BE FOR FOUR (4) DOSES.**

Medication being provided by (check applicable box below):

- Physician's office                      OR                       Specialty Pharmacy - BriovaRx

**\*\*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: 11/16/2017  
REVISED/UPDATED: 3/31/2018