

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) (IV INFUSION ONLY) (J-3262) (*Medical*).

DRUG INFORMATION: Complete ALL information below authorization process will be delayed.

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 or 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*)

<input type="checkbox"/> methotrexate	<input type="checkbox"/> sulfasalazine
<input type="checkbox"/> azathioprine	<input type="checkbox"/> leflunomide
<input type="checkbox"/> auranofin	<input type="checkbox"/> hydroxychloroquine
<input type="checkbox"/> 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(es) below.

- Location/site of drug administration: _____
NPI or DEA # of administering location: _____

OR

- Specialty Pharmacy: Briova SpecialtyRx

****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: 6/17/2010

REVISED/UPDATED: 6/2/2011; 8/11/2011; 9/14/2011; 4/17/2012; 10/1/2012; 1/16/2014; 2/6/2014; 4/28/2014; 5/22/2014; 6/30/2014; 8/8/2014; 10/1/2014; 10/31/2014; 11/21/2014; 4/2/2015; 5/23/2015; 1/29/2016; 3/30/2016; 9/22/2016; 12/28/2016; 1/3/2017; 8/1/2017; 7/10/2018