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 1-844-723-2094. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. If information provided is NOT complete, correct, or legible, authorization will be delayed.

For Medicare Members: Medicare Coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. Additional indications may be covered at the discretion of the health plan.

SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS (sJIA)

Drug Requested: ILARIS® (canakinumab) (J0638) (Medical) (Non-Preferred)

Medication can ONLY be provided by a Physician's office

- URGENT REVIEW. In checking this box, prescriber attests to the fact that by applying the standard review timeframe may seriously jeopardize the member’s life, health, or ability to regain maximum function.

- STANDARD REVIEW. In checking this box, the timeframe does NOT jeopardize the life or health of the member or the member’s ability to regain maximum function and would NOT subject the member to severe pain.

DRUG INFORMATION: Complete all information below or authorization will be delayed.

Drug Form/Strength:

Dosing Schedule: ____________________________ Length of Therapy: ______________

Diagnosis: ____________________________ ICD Code: ______________________

Recommended dosage: every 4 weeks SQ: 4mg/kg (with a maximum of 300mg) > 7.5kg

CLINICAL CRITERIA: Check below ALL that apply. ALL criteria must be met for approval. To support each line checked, ALL documentation, including lab results, diagnostics, and/or chart notes, must be provided or request will be denied. (Medical notes and lab results MUST be attached to support lab values and diagnosis.)

Initial approval: 3 months. For continued 12-month approval, please refax form with documentation of CRP or ESR along with progress notes to document therapy effective.

- Members must be aged 2 years - 17 years
- Member must have had persistent sJIA activity for a minimum of six (6) months
  Date of diagnosis must be noted
- Member must have trial and failure of NSAIDs and corticosteroids for > 3 months consecutively within the last 4 months (paid claims will be reviewed for verification)

(Continued on next page)
AND

- Member must have trial and failure of NSAIDs and corticosteroids for > 3 months consecutively within the last 4 months (paid claims will be reviewed for verification)

AND

- Member must have had ≥ 5 active joints with concomitant fever for at least 2 weeks within the last 3 months of this request

OR

- Member must have had > 2 active joints with concomitant fever for at least 5 days and trial of prednisone or equivalent dosed at 0.5mg/kg/day or 30mg/day within the last 3 months of this request

AND

- Member must have had CRP (>15 mg/L) within the last 2 months of this year

AND

- Member must have had ESR (>45mm/hr) within the last 2 months of this year

AND

- Member must have had fever > 38°C or 100.4°F for at least 2 weeks within the last 2 months of this request

AND

- Member must have documented failure of Actemra® (failure is defined as paid claims of Actemra® for at least 6 months AND lab values above did not respond to the preferred drug)

OR

- Member has history of anaphylactic reaction to Actemra® [anaphylaxis is defined as an emergency department (ER/ED) visit due to throat or tongue swelling and/or shortness of breath] or development of skin reactions that lead to Stevens Johnson syndrome.

Progress notes and labs documenting anaphylactic reaction or development of SJS MUST be submitted.

**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.*

Member 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:  6/21/2018*

REVISED/UPDATED: 2019-03-15 (Reformatted) 9/29/2018