

# 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 1-800-750-9692. 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):**

<input type="checkbox"/> Neurologist	<input type="checkbox"/> Rheumatologist	<input type="checkbox"/> Ophthalmologist
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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)

<input type="checkbox"/> Granulomatous inflammation of the blood vessel wall	<input type="checkbox"/> Disruption and fragmentation of internal elastic lamina	<input type="checkbox"/> Giant cells
<input type="checkbox"/> Proliferation of the intima with associated occlusion of the lumen	<input type="checkbox"/> 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**