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*:** _____

CLINICAL CRITERIA: Check applicable boxes below. Boxes must be checked to qualify. Test results in chart documentation MUST be attached with request. If incomplete, authorization will be delayed.

- ❑ **Prescriber is a Rheumatologist**
- ❑ Diagnosis of giant cell arteritis (GCA) in adult patients
  - ❑ ***Recommended Dose:*** 162 mg given once every week as a subcutaneous injection, in combination with a tapering course of glucocorticoids.
  - ❑ Approval will be based on Week 52 and patient shows sustained remission as defined absence of symptoms of giant cell arteritis

***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