# 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. **Incomplete form will delay the authorization process**.

**Drug Requested:** **Actemra®** (tocilizumab) (**IV INFUSION ONLY**) (**J-3262**) **(Medical)**.

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

**Drug Form/Strength:** _____

**Dosing Schedule:** _____ **Length of Therapy**: _____

**Diagnosis:** _____ **ICD Code:** _____

**Weight:** _____ **kg** **Date within last 30 days:**_____

**CLINICAL CRITERIA:** Information below **must** be completed to ensure authorization will **NOT** be delayed.

**PART A – DMARD therapy:** **Trial and failure of at least ONE (1) DMARD therapy for three (3) months)**

| | |
|---|---|
| ❑ methotrexate | ❑ sulfasalazine |
| ❑ azathioprine | ❑ leflunomide |
| ❑ auranofin | ❑ hydroxychloroquine |
| ❑ Other: _____ | |

❑ **DIAGNOSIS: Rheumatoid Arthritis (RA) –** all boxes that apply **must** be checked to qualify.

- ❑ Prescriber is a Rheumatologist
- ❑ Patient has tried and failed **at least one (1)** previous **DMARD** therapy including but not limited to: **(REFER TO PART A for list of DMARD therapy drugs; check each tried)**
- ❑ **Patient has tried and failed two (2) of the following**:

| | | |
|---|---|---|
| ❑ **Cimzia™** | ❑ **Simponi® ARIA™** | ❑ **Renflexis®** |

**(Cimzia™, Renflexis®, and Simponi® ARIA™ require prior authorization. Forms can be found at www.Optimahealth.com)**

❑ **DIAGNOSIS: Juvenile Idiopathic Arthritis (JIA) –**boxes that apply **must** be checked to qualify.

- ❑ Prescriber is a Rheumatologist
- ❑ Trial and failure of at least **one (1) DMARD** therapy **(REFER TO PART A for list of DMARD therapy drugs; check each tried)**

**(continued on next page)**

❑ **DIAGNOSIS: Systemic Juvenile Idiopathic Arthritis (sJIA) –** all boxes that apply **must** be checked to qualify.

- ❑ Prescriber is a Rheumatologist
- ❑ Patient must be aged 2 years- 17years
- ❑ Patient must have persistent sJIA activity for a minimum of six months. Date of diagnosis: _____
- ❑ Trial and failure of NSAIDs and corticosteroids for >3 months (history of claims will be reviewed)
- ❑ ≥5 active joints with fever for at least 2 weeks **OR**
- ❑ ≥2 active joints with fever for at least 5 days and taking prednisone or equivalent 0.5mg/kg/day or 30mg/day
- ❑ CRP >15mg/L OR
- ❑ High ESR >45mm/hr
- ❑ Fever >38º C or 100.4º F for at least two (2) weeks

**Medication being provided by - check applicable box(es) below.**

❑ **Location/site of drug administration:** _____

**NPI or DEA # of administering location:** _____

**OR**

❑ **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**: 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; 5/18/2018; 10/12/2018;~~ **12/31/2018**