# 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: Please complete below. Incomplete information will delay the authorization process.***

**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. 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)***

| | |
|---|---|
| ❑ methotrexate | ❑ sulfasalazine |
| ❑ azathioprine | ❑ leflunomide |
| ❑ auranofin | ❑ hydroxychloroquine |
| ❑ 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: 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**