# SENTARA COMMUNITY PLAN
# (MEDICAID)

## 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 1-844-305-2331**. 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 can be delayed**.

**Drug Requested: Non-Preferred tocilizumab products for IV infusion only (Medical)**

| | | |
|---|---|---|
| ❑ **Actemra®** (tocilizumab) **(J3262)** | ❑ **Tofidence™** (tocilizumab- bavi) **(Q5133)** | ❑ **Tyenne®** (tocilizumab-aazg) **(Q5135)** |

**MEMBER & PRESCRIBER INFORMATION:** Authorization may be delayed if incomplete.

**Member Name:** _____

**Member Sentara #:** _____ **Date of Birth:** _____

**Prescriber Name:** _____

**Prescriber Signature:** _____ **Date:** _____

**Office Contact Name:** _____

**Phone Number:** _____ **Fax Number:** _____

**NPI #:** _____

**DRUG INFORMATION:** Authorization may be delayed if incomplete.

**Drug Name/Form/Strength:** _____

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

**Diagnosis:** _____ **ICD Code, if applicable:** _____

**Weight (if applicable):** _____ **Date weight obtained:** _____

❑ 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.

| Diagnosis & Drug | Recommended Dose |
|---|---|
| ❑ **Rheumatoid Arthritis (RA) –** Actemra®, Tyenne® & Tofidence™ | • 4 to 8mg/kg every 28 days |
| ❑ **Polyarticular Juvenile Idiopathic Arthritis (PJIA) –** Actemra®, Tyenne® & Tofidence™ | • Weight <30kg: 10mg/kg every 28 days<br>• Weight ≥ 30kg: 8mg/kg every 28 days |
| ❑ **Systemic Juvenile Idiopathic Arthritis (SJIA) –** Actemra®, Tyenne® & Tofidence™ | • Weight <30kg: 12mg/kg every 14 days<br>• Weight ≥ 30kg:8mg/kg every 14 days |

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| Diagnosis & Drug | Recommended Dose |
|---|---|
| ❑ **Giant Cell Arteritis (GCA) –** Actemra® & Tyenne® only | • 6mg/kg every 28 days |
| ❑ **Cytokine Release Syndrome –** Actemra® only | • 30 kg or more: 8mg/kg for one dose, up to 3 additional doses if no clinical improvement (max dose 800mg)<br>• Less than 30kg: 12 mg/kg for one dose, up to 3 additional doses if no clinical improvement (max dose 800mg) |

**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 may be denied.

**PART A – DMARD therapy: Trial and failure of at least ONE (1) DMARD therapy other than methotrexate**

| | | |
|---|---|---|
| ❑ sulfasalazine | ❑ azathioprine | ❑ leflunomide |
| ❑ auranofin | ❑ hydroxychloroquine | ❑ gold salts |
| ❑ d-penicillamine | ❑ cyclosporine | ❑ cyclophosphamide |
| ❑ tacrolimus | ❑ Other: _____ | |

## ❑ Diagnosis: Rheumatoid Arthritis (RA)

- ❑ Prescriber is a Rheumatologist; **AND**
- ❑ Member has moderate to severe rheumatoid arthritis; **AND**
- ❑ Tried and failed methotrexate; **OR**
- ❑ Requested medication will be used in conjunction with methotrexate; **OR**
- ❑ Member has a contraindication to methotrexate (e.g., alcohol abuse, cirrhosis, chronic liver disease, or other contraindication); **AND**
- ❑ Member 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); AND**
- ❑ Member has trial and failure of **TWO (2)** of the **PREFERRED** biologics below:

| | | |
|---|---|---|
| ❑ Humira® | ❑ Enbrel® | ❑ Infliximab |

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## ❑ Diagnosis: Systemic Juvenile Idiopathic Arthritis (sJIA)

- ❑ Prescriber is a Rheumatologist; **AND**
- ❑ Member is 2 years of age and older with active systemic juvenile idiopathic arthritis; **AND**
- ❑ Tried and failed methotrexate; **OR**
- ❑ Requested medication will be used in conjunction with methotrexate; **OR**
- ❑ Member has a contraindication to methotrexate (e.g., alcohol abuse, cirrhosis, chronic liver disease, or other contraindication); **AND**
- ❑ Member 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)**

## ❑ Diagnosis: Giant Cell Arteritis

- ❑ **For Actemra® & Tyenne® requests only:** Member must be 18 years of age and older with giant cell arteritis (GCA) diagnosis

## ❑ Diagnosis: Polyarticular Juvenile Idiopathic Arthritis (PJIA)

- ❑ Prescriber is a Rheumatologist; **AND**
- ❑ Member must be 2 years of age and older with active polyarticular juvenile idiopathic arthritis; **AND**
- ❑ Tried and failed methotrexate; **OR**
- ❑ Requested medication will be used in conjunction with methotrexate; **OR**
- ❑ Member has a contraindication to methotrexate (e.g., alcohol abuse, cirrhosis, chronic liver disease, or other contraindication); **AND**
- ❑ Trial and failure of **TWO (2)** of the **PREFERRED** biologics below:

| | |
|---|---|
| ❑ Humira® | ❑ Enbrel® |

- ❑ Member 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)**

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## ❑ Diagnosis: Cytokine Release Syndrome

**For Actemra® requests only:** Members is 2 years of age and older with chimeric antigen receptor (CAR) T cell-induced severe or life-threatening cytokine release syndrome.

## Medication being provided by: Please check applicable box below.

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

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

For urgent reviews: Practitioner should call Sentara Health Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Sentara Health's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

***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.***

**REVISED/UPDATED/REFORMATTED**: ~~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; 2/4/2019; 5/4/2019; 7/21/2019; 10/15/2019; 10/16/2020; 6/24/2021; 7/19/2021; 6/29/2022; 6/22/2023, 9/30/2024; 12/13/2024~~**,03/25/2025**