

# 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:** Actemra® (tocilizumab) (**IV INFUSION ONLY**) (J-3262)  
**(Medical) (Non-Preferred)**

**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: \_\_\_\_\_

DEA OR NPI #: \_\_\_\_\_

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

Drug Form/Strength: \_\_\_\_\_

Dosing Schedule: \_\_\_\_\_ Length of Therapy: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD Code, if applicable: \_\_\_\_\_

Weight: \_\_\_\_\_ Date: \_\_\_\_\_

- 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	Recommended Dose
<input type="checkbox"/> Rheumatoid Arthritis (RA)	<ul style="list-style-type: none"> <li>• 4 to 8mg/kg every 28 days</li> </ul>
<input type="checkbox"/> Polyarticular Juvenile Idiopathic Arthritis (PJIA)	<ul style="list-style-type: none"> <li>• Weight &lt;30kg: 10mg/kg every 28 days</li> <li>• Weight ≥ 30kg: 8mg/kg every 28 days</li> </ul>
<input type="checkbox"/> Systemic Juvenile Idiopathic Arthritis (SJIA)	<ul style="list-style-type: none"> <li>• Weight &lt;30kg: 12mg/kg every 14 days</li> <li>• Weight ≥ 30kg: 8mg/kg every 14 days</li> </ul>

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DIAGNOSIS	Recommended Dose
<input type="checkbox"/> Giant Cell Arteritis (GCA)	<ul style="list-style-type: none"> <li>6mg/kg every 28 days</li> </ul>
<input type="checkbox"/> Cytokine Release Syndrome	<ul style="list-style-type: none"> <li>30 kg or more: 8mg/kg for one dose, up to 3 additional doses if no clinical improvement (max dose 800mg)</li> <li>Less than 30kg: 12 mg/kg for one dose, up to 3 additional doses if no clinical improvement (max dose 800mg)</li> </ul>

**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

<input type="checkbox"/> sulfasalazine	<input type="checkbox"/> azathioprine	<input type="checkbox"/> leflunomide
<input type="checkbox"/> auranofin	<input type="checkbox"/> hydroxychloroquine	<input type="checkbox"/> gold salts
<input type="checkbox"/> d-penicillamine	<input type="checkbox"/> cyclosporine	<input type="checkbox"/> cyclophosphamide
<input type="checkbox"/> tacrolimus	<input type="checkbox"/> 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:

<input type="checkbox"/> Humira®	<input type="checkbox"/> Enbrel®	<input type="checkbox"/> Infliximab
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**Diagnosis: Systemic Juvenile Idiopathic Arthritis (sJIA)**

- Prescriber is a Rheumatologist; **AND**

