

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)**

<input type="checkbox"/> Actemra[®] (tocilizumab) (J3262)	<input type="checkbox"/> Tofidence[™] (tocilizumab-bavi) (Q5133)	Tyenne[®] (tocilizumab-aazg) (Q5135)
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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 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
<input type="checkbox"/> Rheumatoid Arthritis (RA) – Actemra [®] , Tyenne [®] & Tofidence [™]	<ul style="list-style-type: none"> 4 to 8mg/kg every 28 days
<input type="checkbox"/> Polyarticular Juvenile Idiopathic Arthritis (PJIA) – Actemra [®] , Tyenne [®] & Tofidence [™]	<ul style="list-style-type: none"> Weight <30kg: 10mg/kg every 28 days Weight ≥ 30kg: 8mg/kg every 28 days
<input type="checkbox"/> Systemic Juvenile Idiopathic Arthritis (SJIA) – Actemra [®] , Tyenne [®] & Tofidence [™]	<ul style="list-style-type: none"> Weight <30kg: 12mg/kg every 14 days Weight ≥ 30kg: 8mg/kg every 14 days

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PA Non-Preferred tocilizumab products IV (MEDICAL) (Medicaid)
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DIAGNOSIS	Recommended Dose
<input type="checkbox"/> Giant Cell Arteritis (GCA) – Actemra® & Tyenne® only	<ul style="list-style-type: none"> 6mg/kg every 28 days
<input type="checkbox"/> Cytokine Release Syndrome – Actemra® only	<ul style="list-style-type: none"> 30 kg or more: 8mg/kg for one dose, up to 3 additional doses if no clinical improvement (max dose 800mg) 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

<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**

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- 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)**

Diagnosis: Cytokine Release Syndrome

- For Actemra® requests only:** Member has a confirmed diagnosis of cytokine release syndrome

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Medication being provided by (check box below that applies):

- 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.****