SENTARA COMMUNITY PLAN (MEDICAID)

MEDICAL PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

<u>Directions:</u> 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; <u>fax to 1-844-305-2331</u>. No additional phone calls will be necessary if all information (<u>including phone and fax #s</u>) on this form is correct. <u>If information provided is not complete, correct, or legible, authorization can be delayed</u>.

<u>Drug Requested</u>: Actemra® (tocilizumab) (<u>IV INFUSION ONLY</u>) (J-3262) (<u>Medical</u>) (<u>Non-Preferred</u>)

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			
Drug Form/Strength:			
Dosing Schedule: Length of Therapy:			
iagnosis: ICD Code, if applicable:			
Weight:	Date:		
	eframe does not jeopardize the life or health of the member tion and would not subject the member to severe pain.		
DIAGNOSIS	Recommended Dose		
□ Rheumatoid Arthritis (RA)	• 4 to 8mg/kg every 28 days		
□ Polyarticular Juvenile Idiopathic Arthritis (PJIA)	 Weight <30kg: 10mg/kg every 28 days Weight ≥ 30kg: 8mg/kg every 28 days 		
☐ Systemic Juvenile Idiopathic Arthritis (SJIA)	 Weight <30kg: 12mg/kg every 14 days Weight > 30kg:8mg/kg every 14 days 		

DIAGNOS	IS	R	ecommended Dose	
☐ Giant Cell Arteritis (GCA)		• 6mg/kg every 28 days		
□ Cytokine Release Syndrome		 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				
□ sulfasalazine	□ azathioprine		□ leflunomide	
□ auranofin	□ hydroxychloroqu	ine	☐ 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	☐ 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 <u>TWO(2)</u> of the <u>PREFERRED</u> biologics below:				
☐ Humira®	□ Enbrel®)	□ Infliximab	
	,			
□ Diagnosis: Systemic Juvenile Idiopathic Arthritis (sJIA)				
☐ Prescriber is a Rheumato	logist; AND			

(Continued on next page)

	Member is 2 years of age and older with active s	ystemic juvenile idiopathic arthritis; AND	
	Tried and failed methotrexate; OR		
	Requested medication will be used in conjunction	n with methotrexate; OR	
	Member has a contraindication to methotrexate (other contraindication); AND	e.g., alcohol abuse, cirrhosis, chronic liver disease, or	
	Member tried and failed at least one (1) previou TO PART A for list of DMARD therapy drug	s DMARD therapy including but not limited to:(REFEF s; check each tried)	
□ D	Diagnosis: Giant Cell Arteritis		
	Member must be 18 years of age and older with	giant cell arteritis (GCA) diagnosis	
u D	Diagnosis: Polyarticular Juvenile Idiopat	thic 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	n with methotrexate; OR	
	Member has a contraindication to methotrexate (other contraindication); AND	e.g., alcohol abuse, cirrhosis, chronic liver disease, or	
	Trial and failure of TWO (2) of the PREFERR	ED biologics below:	
	☐ Humira [®]	□ Enbrel®	
	Member tried and failed <u>at least one (1)</u> previou (REFER TO PART A for list of DMARD thera		
□ D	Diagnosis: Cytokine Release Syndrome		
	Member has a confirmed diagnosis of cytokine r	elease syndrome	
Med	lication being provided by (check box below	w that applies):	
	Location/site of drug administration:		
	NPI or DEA # of administering location:		
	OR		
	Physician's office OR	□ Specialty Pharmacy – PropriumRx	
or ur	gent reviews: Practitioner should call Sentara Hea	Ith Pre-Authorization Department if they believe a	

standard reviews: Practitioner should can 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.