AvMed

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 1-877-535-1391**. 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**.

For Medicare Members: Medicare Coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. Additional indications may be covered at the discretion of the health plan.

IV tocilizumab products - Giant Cell Arteritis (GCA)

Drug Requested: select one drug below **(Medical)**

PREFERRED	
❑ **Actemra® IV** (tocilizumab) **(J3262)**	**Tyenne™ IV** (tocilizumab-aazg) **(Q5135)**
NON-PREFERRED	
❑ **Tofidence™ IV** (tocilizumab-bavi) **(Q5133)** ***Member must have tried and failed BOTH preferred agents and meet all PA criteria for approval of Tofidence***	

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

Member Name: _____

Member AvMed #: _____ **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.

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Recommended Dosing: **IV (Actemra and tocilizumab biosimilars):** 6 mg/kg (maximum dose: 600 mg) once every 4 weeks in combination with glucocorticoids

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.

Initial Authorization: 12 months

- ❑ Prescribed by or in consultation with **ONE** of the following:
  - ❑ Neurologist
  - ❑ Ophthalmologist
  - ❑ Rheumatologist
- ❑ Member has diagnosis of Giant Cell Arteritis (GCA) with large vessel arteritis that has at some point been verified with biopsy or with imaging of the large vessels (e.g., color Doppler ultrasound [CDUS], MRI, PET-CT, or CT angiography)
- ❑ Member is at least 18 years of age
- ❑ Member has tried one systemic corticosteroid
- ❑ **For Tofidence™ requests:** Member must have tried and failed **BOTH** preferred agents Actemra™ and Tyenne™ **AND** meet all prior authorization criteria for approval of Tofidence™

Reauthorization: 12 months. 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.

- ❑ Member has experienced disease response as indicated by improvement in signs and symptoms compared to baseline such as headache, temporal artery tenderness, visual symptoms, inflammatory parameters (e.g., erythrocyte sedimentation rate [ESR], C-reactive protein), improvement of periodic imaging studies (color Doppler ultrasound [CDUS], MRI, PET-CT, or CT angiography

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Medication being provided by: Please check applicable box below.

- ❑ **Location/site of drug administration:** _____
  NPI or DEA # of administering location: _____

  OR

- ❑ **Specialty Pharmacy**

For urgent reviews: Practitioner should call AvMed Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. AvMed'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.