

# SENTARA COMMUNITY PLAN (MEDICAID)

## PHARMACY 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 1-800-750-9692.** No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

**Drug Requested:** Actemra (tocilizumab) and Tyenne® (tocilizumab-aazg) SQ (Pharmacy) (Non-Preferred)

<input type="checkbox"/> <b>Actemra®</b> (tocilizumab)	<input type="checkbox"/> <b>Tyenne®</b> (tocilizumab-aazg)
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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 Name/Form/Strength: \_\_\_\_\_

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

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

Weight (if applicable): \_\_\_\_\_ Date weight obtained: \_\_\_\_\_

DIAGNOSIS	Recommended Dose
<input type="checkbox"/> <b>Rheumatoid Arthritis (RA)</b>	<b>SUBCUTANEOUS</b> <ul style="list-style-type: none"> <li>• <b>Weight &lt;100kg:</b> Two syringes per 28 days. Max dose is 4 syringes per 28 days</li> <li>• <b>Weight &gt;100kg:</b> Four syringes per 28 days</li> </ul>
<input type="checkbox"/> <b>Polyarticular Juvenile Idiopathic Arthritis (PJIA)</b>	<b>SUBCUTANEOUS</b> <ul style="list-style-type: none"> <li>• <b>Weight &lt;30kg:</b> 162mg/dose once every 3 weeks</li> <li>• <b>Weight ≥30kg:</b> 162mg/dose once every 2 weeks</li> </ul>
<input type="checkbox"/> <b>Systemic Juvenile Idiopathic Arthritis (SJIA)</b>	<b>SUBCUTANEOUS</b> <ul style="list-style-type: none"> <li>• <b>Weight &lt;30kg:</b> 162mg/dose once every 3 weeks</li> <li>• <b>Weight ≥30kg:</b> 162mg/dose every 2 weeks</li> </ul>

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**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.

**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**
- Tried and failed at least **ONE (1) DMARD** other than methotrexate and (check each tried)

<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: _____	

**AND**

- 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: 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:

<input type="checkbox"/> Humira®	<input type="checkbox"/> Enbrel®
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**AND**

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- Trial and failure of at least **ONE (1) DMARD** therapy **and** (check each tried)

<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: Systemic Juvenile Idiopathic Arthritis (SJIA)**

- Prescriber is a Rheumatologist; **AND**
- Member must be 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**
- Trial and failure of at least **ONE (1) DMARD** therapy **and** (check each tried)

<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: _____	

**Medication being provided by Specialty Pharmacy - PropriumRx**

***\*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.\****