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)

❑ **Actemra®** (tocilizumab)	❑ **Tyenne®** (tocilizumab-aazg)

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
❑ **Rheumatoid Arthritis (RA)**	**SUBCUTANEOUS** • **Weight <100kg**: Two syringes per 28 days. Max dose is 4 syringes per 28 days • **Weight >100kg:** Four syringes per 28 days
❑ **Polyarticular Juvenile Idiopathic Arthritis (PJIA)**	**SUBCUTANEOUS** • **Weight <30kg:** 162mg/dose once every 3 weeks • **Weight ≥30kg:** 162mg/dose once every 2 weeks
❑ **Systemic Juvenile Idiopathic Arthritis (SJIA)**	**SUBCUTANEOUS** • **Weight <30kg:** 162mg/dose once every 2 weeks • **Weight ≥30kg:** 162mg/dose every week

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DIAGNOSIS	Recommended Dose
❑ **Giant Cell Arteritis (GCA)**	**SUBCUTANEOUS** • 162mg once a week, may consider 162mg once every 2 weeks
❑ **Systemic Sclerosis- Associated Interstitial Lung Disease (SSc-ILD)** - Actemra® only	**SUBCUTANEOUS** • 162mg once a week

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)

- ❑ Member has moderate to severe rheumatoid arthritis
- ❑ Trial and failure of one conventional synthetic disease modifying anti-rheumatic drug (csDMARD) (e.g. methotrexate, azathioprine, hydroxychloroquine, penicillamine, sulfasalazine, leflunomide, etc.)
- ❑ Trial and failure of **TWO (2)** of the preferred biologics below:

❑ adalimumab-adbm (Boehringer Ingelheim) **OR** Hadlima® (adalimumab-bwwd)	❑ Enbrel®

❑ Diagnosis: Polyarticular Juvenile Idiopathic Arthritis (PJIA)

- ❑ Member must be 2 years of age and older with active polyarticular juvenile idiopathic arthritis
- ❑ Trial and failure of either oral non-steroidal anti-inflammatory drugs (NSAIDs) OR one conventional synthetic disease modifying antirheumatic drug (csDMARD) (e.g. methotrexate, azathioprine, hydroxychloroquine, penicillamine, sulfasalazine, leflunomide, etc.)
- ❑ Trial and failure of **BOTH** of the preferred biologics below:

❑ adalimumab-adbm (Boehringer Ingelheim) **OR** Hadlima® (adalimumab-bwwd)	❑ Enbrel®

❑ Diagnosis: Systemic Juvenile Idiopathic Arthritis (SJIA)

- ❑ Member must be 2 years of age and older with active systemic juvenile idiopathic arthritis
- ❑ Trial and failure of **BOTH** of the preferred biologics below:

❑ adalimumab-adbm (Boehringer Ingelheim) **OR** Hadlima® (adalimumab-bwwd)	❑ Enbrel®

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❑ Diagnosis: Giant Cell Arteritis (GCA)

- ❑ Member must be 18 years of age or older with giant cell arteritis (GCA) diagnosis

❑ Diagnosis: Systemic Sclerosis- Associated Interstitial Lung Disease (SSc-ILD)

- ❑ **For Actemra® requests only:** Member must be 18 years of age or older with systemic sclerosis-associated interstitial lung disease (SSc-ILD)

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.*

***REVISED/REFORMATTED/UPDATED:** ~~8/20/2024; 9/30/2024; 12/12/2024; 3/24/2025; 10/17/2025, 12/9/2025;~~ **7/9/2026**