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: (Select drug below) (Pharmacy) (Non-Preferred)

❑ **Actemra®** (tocilizumab)	❑ **Avtozma®** (tocilizumab-anoh)	❑ **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;
- ❑ 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)
- ❑ Tried and failed at least **ONE (1) DMARD** other than methotrexate (check each tried):

❑ sulfasalazine	❑ azathioprine	❑ leflunomide
❑ auranofin	❑ hydroxychloroquine	❑ gold salts
❑ d-penicillamine	❑ cyclosporine	❑ cyclophosphamide
❑ tacrolimus	❑ Other: _____	

- ❑ Trial and failure of **TWO (2)** of the preferred biologics below:

❑ Humira®	❑ Enbrel®	❑ Infliximab

❑ Diagnosis: Polyarticular Juvenile Idiopathic Arthritis (PJIA)

- ❑ Member must be 2 years of age and older with active polyarticular juvenile idiopathic arthritis
- ❑ 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)

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

❑ sulfasalazine	❑ azathioprine	❑ leflunomide
❑ auranofin	❑ hydroxychloroquine	❑ gold salts
❑ d-penicillamine	❑ cyclosporine	❑ cyclophosphamide
❑ tacrolimus	❑ Other: _____	

- ❑ Trial and failure of **BOTH** of the preferred biologics below:

❑ Humira®	❑ Enbrel®

❑ Diagnosis: Systemic Juvenile Idiopathic Arthritis (SJIA)

- ❑ Member must be 2 years of age and older with active systemic juvenile idiopathic arthritis
- ❑ 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 other than methotrexate (check each tried):

❑ sulfasalazine	❑ azathioprine	❑ leflunomide
❑ auranofin	❑ hydroxychloroquine	❑ gold salts
❑ d-penicillamine	❑ cyclosporine	❑ cyclophosphamide
❑ tacrolimus	❑ Other: _____	

- ❑ Trial and failure of **BOTH** of the preferred biologics below:

❑ Humira®	❑ Enbrel®

❑ Diagnosis: Giant Cell Arteritis (GCA)

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

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❑ 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.*