SENTARA COMMUNITY PLAN
(MEDICAID)

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 1-844-305-2331**. 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**.

Drug Requested: Actemra® (tocilizumab) (**J-3262**) **(Medical)**
Cytokine Release Syndrome (CRS*)*

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 be delayed if incomplete.

Drug Form/Strength: ______________________________

Dosing Schedule: ____________________ **Length of Therapy**: ____________________

Diagnosis: ____________________ **ICD Code, if applicable:** ____________________

Weight: ____________________ **Date:** ____________________

Recommended dose for treatment of CRS given as a 60-minute intravenous infusion:

Patients less than 30 kg weight: 12mg per kg
Patients at or above 30 kg weight: 8 mg per kg

Doses exceeding 800 mg per infusion are not recommended in CRS patients.

Subcutaneous administration is not approved for CRS.

❑ Standard Reviews. 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.

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.

(Continued on next page)

- **Has member been approved by their insurance for chimeric antigen receptor (CAR) T-cell therapy?** ❑ **YES** ❑ **NO**

If clinical improvement does **NOT** occur after the first dose, up to **3 additional doses** may be administered (with at least an 8-hour interval between consecutive doses). Tocilizumab may be administered as monotherapy or in combination with corticosteroids.

APPROVAL WILL BE FOR FOUR (4) DOSES.

Medication being provided by (check box below that applies):

❑ **Location/site of drug administration:** ____

NPI or DEA # of administering location: ____

OR

❑ **Specialty Pharmacy – PropriumRx**

For urgent reviews: Practitioner should call Sentara Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Sentara defines a request as urgent where applying the routine decision timeframe 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.****