OPTIMA HEALTH 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 information provided is not complete, correct, or legible, authorization will be delayed.**

Drug Requested: Actemra® SQ (tocilizumab) **(self-administered) (Pharmacy) (Non-Preferred)**

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

Member Name: _____

Member Optima #: _____ **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:** _____

Weight: _____ **Date:** _____

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 3 weeks • **Weight ≥30kg:** 162mg/dose every 2 weeks
❑ **Giant Cell Arteritis (GCA)**	**SUBCUTANEOUS** • Max adult dose is 4 syringes per 28 days
❑ **Systemic Sclerosis Associated Interstitial Lung Disease (SSc-ILD)**	**SUBCUTANEOUS** • Max adult dose is 4 syringes per 28 days

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CLINCIAL 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 DMARD** other than methotrexate and **(check each tried)**

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

AND

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

❑ Humira®	❑ Enbrel®	❑ Infliximab

❑ 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:

❑ Humira®	❑ Enbrel®

AND

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

❑ sulfasalazine	❑ azathioprine	❑ leflunomide
❑ auranofin	❑ hydroxychloroquine	❑ gold salts
❑ d-penicillamine	❑ cyclosporine	❑ cyclophosphamide
❑ tacrolimus	❑ 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)**

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

❑ Diagnosis: Giant Cell Arteritis (GCA)

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

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

- ❑ Member must be 18 years of age and has a confirmed diagnosis of systemic sclerosis-associated interstitial lung disease (SSc-ILD)

Medication being provided by (check applicable box(es) below):

❑ Physician's office **OR** ❑ 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.