AvMed

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 1-305-671-0200**. 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® SQ** (tocilizumab) (self-administered) **(Pharmacy)**
Systemic Sclerosis-associated Interstitial Lung Disease

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

Member Name: _____

Member AvMed #: _____ **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:** _____

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: Systemic Sclerosis-associated Interstitial Lung Disease
Dosing: SubQ - 162mg once every week

Initial Authorization: 12 months

All of the following criteria must be met:

- ❑ Medication is prescribed by or in consultation with a pulmonology specialist
- ❑ Diagnosis of systemic sclerosis has been confirmed with an American College of Rheumatology (ACR)/European League Against Rheumatism (EULAR) classification criteria score ≥ 9

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- ❑ Onset of disease (first non-Raynaud symptom) occurred ≤ 5 years ago
- ❑ Member has worsening disease despite concomitant use of low-dose corticosteroids (e.g., prednisone ≤ 10mg/day) and stable doses of immunosuppressant therapy (e.g., mycophenolate, methotrexate, cyclophosphamide)
- ❑ Member's baseline percent forced vital capacity (%FVC) must be ≥ 55%
- ❑ Member's baseline percent predicted diffusing capacity of the lungs for carbon monoxide (%DLCO, corrected for hemoglobin) must be >45%
- ❑ No concomitant use of OFEV and Esbriet

Reauthorization Approval: 12 months. 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.

- ❑ Member has experienced disease response as indicated by a reduction in the rate of decline or stabilization in forced vital capacity (%FVC) or percent predicted FVC (ppFVC) as compared to pre-treatment baseline
- ❑ Member does not have evidence of disease progression defined as an absolute decline of more than 10% in percent predicted FVC within any 12-month period

Medication being provided by Specialty Pharmacy - PropriumRx

Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

****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.****

***Approved by Pharmacy and Therapeutics Committee**: ~~1/17/2019;~~ 10/15/2020
REVISED/UPDATED/REFORMATTED: 10/30/2023