AvMed

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 1-877-535-1391**. 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**.

For Medicare Members: Medicare Coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. Additional indications may be covered at the discretion of the health plan.

Drug Requested: ACTEMRA® (tocilizumab) – **(J-3262) (Medical)**
{Cytokine Release Syndrome (CRS)}

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:** _____

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:** _____

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.

(Continued on next page)

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.

- **Has member been approved by their insurance for chimeric antigen receptor (CAR) T cell therapy?**

  ❑ **YES OR ❑ 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 TOTAL OF FOUR (4) DOSES ONLY.

(Please ensure signature page is attached to form.)

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

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

NPI or DEA # of administering location: _____

OR

❑ **Specialty Pharmacy - PropriumRx**

For urgent reviews: Practitioner should call AvMed Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. AvMed's 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.

***Approved by Pharmacy and Therapeutics Committee**: 11/16/2017
REVISED/UPDATED: ~~3/31/2018; 5/25/2018;~~ **(Reformatted)** ~~3/14/2019; 7/6/2019;~~ **9/16/2019**