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) **(IV Infusion Only) (J-3262) (Medical)**

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:** _____

❑ Standard Review. 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.

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PART A – DMARD therapy: **Trial and failure of at least ONE (1) DMARD therapy for three (3) months)**

❑ methotrexate	❑ sulfasalazine
❑ azathioprine	❑ leflunomide
❑ auranofin	❑ hydroxychloroquine
❑ Other: _____	

❑ DIAGNOSIS - Rheumatoid Arthritis (RA)

- ❑ Prescriber is a **Rheumatologist**

AND

- ❑ Member tried and failed **at least one (1)** previous **DMARD** therapy for three (3) months including but not limited to **(REFER TO PART A for list of DMARD therapy drugs; check each tried)**

AND

- ❑ **Member tried and failed both of the following:**

❑ **Cimzia™**	❑ **Renflexis®**

(Cimzia™ AND Renflexis® require prior authorization. Forms can be found at Providers - AvMed)

❑ DIAGNOSIS - Juvenile Idiopathic Arthritis (JIA)

- ❑ Prescriber is a **Rheumatologist**

AND

- ❑ Trial and failure of at least **one (1) DMARD** therapy **(REFER TO PART A for list of DMARD therapy drugs; check each tried)**

❑ DIAGNOSIS - Systemic Juvenile Idiopathic Arthritis (sJIA)

- ❑ Prescriber is a **Rheumatologist**

AND

- ❑ Member must be aged 2 years- 17years

AND

- ❑ Member must have persistent sJIA activity for a minimum of six months

AND

- ❑ Date of diagnosis: _____

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- ❑ Trial and failure of NSAIDs and high dose corticosteroids for >3 months **(history of claims will be reviewed)**

AND

- ❑ ≥5 active joints with fever for at least 2 weeks

OR

- ❑ ≥2 active joints with fever for at least 5 days and taking prednisone or equivalent 0.5mg/kg/day or 30mg/day
- ❑ CRP >15mg/L

AND

- ❑ High ESR >45mm/hr

AND

- ❑ Fever >38° C or 100.4° F for at least two (2) weeks

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

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

  NPI or DEA # of administering location: _____

OR

- ❑ **Physician's office** **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 Health Plan's definition of urgent is a lack of treatment that 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.****

***Approved by Pharmacy and Therapeutics Committee**: 6/17/2010
REVISED/UPDATED/REFORMATTED: ~~1/29/2016; 3/30/2016; 9/22/2016; 12/28/2016; 1/3/2017; 8/1/2017; 5/18/2018; 10/12/2018; 12/31/2018; 3/14/2019; 5/4/2019; 7/6/2019;~~ **9/16/2019**