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.**

SQ tocilizumab products - Giant Cell Arteritis (GCA)

Drug Requested: select one drug below **(Pharmacy)**

❑ **Actemra® SQ** (tocilizumab)	❑ **Tyenne® SQ** (tocilizumab-aazg)

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 Dosage: 162 mg given once every week as a subcutaneous injection, in combination with a tapering course of glucocorticoids

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.

Initial Authorization: 12 months

- ❑ Prescribed by or in consultation with **ONE** of the following:
  - ❑ Neurologist
  - ❑ Ophthalmologist
  - ❑ Rheumatologist

(Continued on next page)

- ❑ Member has diagnosis of Giant Cell Arteritis (GCA) with large vessel arteritis that has at some point been verified with biopsy or with imaging of the large vessels (e.g., color Doppler ultrasound [CDUS], MRI, PET-CT, or CT angiography)
- ❑ Member is at least 18 years of age
- ❑ Member has tried one systemic corticosteroid

Reauthorization: 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 improvement in signs and symptoms compared to baseline such as headache, temporal artery tenderness, visual symptoms, inflammatory parameters (e.g., erythrocyte sedimentation rate [ESR], C-reactive protein), improvement of periodic imaging studies (color Doppler ultrasound [CDUS], MRI, PET-CT, or CT angiography

Medication being provided by Specialty Pharmacy – Proprium Rx

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.*