



# TEXAS MEDICAID Clinical Edit Prior Authorization tocilizumab (ACTEMRA)

STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING	
Date:	Prescriber First & Last Name:
Patient First & Last Name:	Prescriber NPI:
Patient Address:	Prescriber Address:
Patient ID:	Prescriber Phone:
Patient Date of Birth:	Prescriber Fax:
STEP 2: MEDICATION INFORMATION	
Medication Requested (Name):	Quantity Requested:
Dose Requested:	Dosing Instructions:
Patient's Primary Diagnosis: _____ ICD 10 Code: _____	
Indicate the drug's formulary status: *(Formulary available at <a href="http://www.txvendordrug.com">www.txvendordrug.com</a> ) <input type="checkbox"/> Non-Preferred Drug (NPD or NAP Status, Go to Step 3 - PDL PA Criteria Applies) <b>OR</b> <input type="checkbox"/> Preferred Drug (Go to Step 4) <b>OR</b> <input type="checkbox"/> No Status, Drug is not in a Market Basket (Go to Step 4) <b>OR</b> <input type="checkbox"/> N/A as this request is for a CHIP / PERINATE client (Go to Step 4)	
STEP 3: PDL PRIOR AUTHORIZATION CRITERIA FOR NON-PREFERRED PRODUCT	
1. Has the client failed a 30-day treatment trial with at least one (1) preferred agent in the last 180 days? <input type="checkbox"/> Yes (Go to Step 4, Question 1) <input type="checkbox"/> No (Go to #2)	
2. Is there a documented allergy or contraindication to preferred agents in this class? <input type="checkbox"/> Yes (Go to Step 4, Question 1) <input type="checkbox"/> No (Go to #3)	



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3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?

- Yes (Go to Step 4, Question 1)  No (Deny)

## STEP 4: CLINICAL PRIOR AUTHORIZATION CRITERIA

1. Is the client greater than or equal to ( $\geq$ ) 18 years of age?

- Yes (Go to #2)  No (Go to #5)

2. Does the client have a diagnosis of Rheumatoid Arthritis (RA) in the last 730 days?

- Yes (Go to #4)  No (Go to #3)

3. Does the client have a diagnosis of Giant Cell Arteritis (GCA) or systemic sclerosis-associated interstitial lung disease (SSc-ILD) in the last 730 days?

- Yes (Go to #7)  No (Go to #5)

4. Does the client have one (1) claim for a disease modifying anti-rheumatic drug (DMARD) in the last 180 days?

Examples of DMARDs include azathioprine (IMURAN), cyclosporine (GENGRAF, NEORAL, SANDIMMUNE), hydroxychloroquine (PLAQUENIL), leflunomide (ARAVA), methotrexate (OTREXUP, TREXALL, XATMEP), and sulfasalazine (AZULFIDINE).

- Yes (Go to #7)  
 No - And the request is for continuing therapy (Go to #7)  
 No - And the request is for initial therapy (Deny)

5. Does the client have a diagnosis of Polyarticular Juvenile Idiopathic Arthritis (PJIA) or Systemic Juvenile Idiopathic Arthritis (SJIA) in the last 730 days?

- Yes (Go to #6)  No (Deny)

6. Is the client greater than or equal to ( $\geq$ ) 2 years of age?

- Yes (Go to #7)  No (Deny)

7. Does the client have a serious active infection (including Hepatitis B virus and/or tuberculosis) in the last 180 days?

- Yes (Deny)  No (Approve – 365 days)



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**STEP 5: SIGN AND FAX TO: NAVITUS PRIOR AUTHORIZATION AT: 855-668-8553**

**Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

If criteria not met, submit chart documentation with form citing complex medical circumstances.  
For questions, please call Navitus Customer Care at 1-877-908-6023.