Field Name	Field Description
Prior Authorization Group Description	**Specialty Biological Agents for Systemic Juvenile Idiopathic Arthritis**
Drugs	Actemra IV (tocilizumab) Or any newly marketed agent
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	N/A
Age Restrictions	According to package insert
Prescriber Restrictions	Prescribed by, or in consultation with, a rheumatologist
Coverage Duration	If all of the conditions are met, the request will be approved for 12 month duration.
Other Criteria	**Initial Authorization:** • Member has a diagnosis of systemic juvenile idiopathic arthritis • The medication is being prescribed at an appropriate FDA approved, or compendia supported, dose (for age and weight) • One of the following: o The member has an adequate trial with a formulary NSAID, oral or intravenous glucocorticoids, methotrexate, or leflunomide and as noted in pharmacy claims/medical record data/chart notes/physician attestation, or the member has a documented medical reason (e.g. allergy, intolerance, contraindication) for not using conventional therapy to manage their condition. o The member has sJIA with macrophage activation syndrome (MAS) **Reauthorization:** • The medication is being recommended or prescribed by a rheumatologist at an FDA-approved, or compendia supported, dosage. • The member has been receiving the medication and documentation was provided that the prescriber has evaluated the member and recommends continuation of therapy (clinical benefit). **Continuation of Therapy**:

Revision/Review Date 8/2023	• Members with history (within the past 90 days) of a non-preferred biological agent are not required to try a preferred biological agent, NSAID, , oral or intravenous glucocorticoids, methotrexate, or leflunomide prior to receiving the non-preferred agent. • Members with history (within the past 90 days) of a preferred biological agent are not required to try preferred NSAID, , oral or intravenous glucocorticoids, methotrexate, or leflunomide prior to receiving the preferred biological agent. **Medical Director/Clinical reviewer must override criteria when, in his/her professional judgment, the requested item is medically necessary.**