

OPTIMA FAMILY CARE MEDALLION 4.0

PHARMACY/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 1-844-723-2094. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete form will delay the authorization process.*

Drug Requested: Actemra® (tocilizumab) (IV INFUSION ONLY) (J-3262) (*Medical*).

DRUG INFORMATION: Complete all information below or authorization process will be delayed.

Drug Form/Strength/Month: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code: _____

CLINICAL CRITERIA: Check all that apply. Applicable boxes must be checked to ensure the authorization process will NOT be delayed.

- Prescriber is a Rheumatologist
- Patient has tried and failed at least one (1) previous **DMARD** therapy including but not limited to: (*check each that have been tried*)
 - methotrexate
 - azathioprine
 - auranofin
 - hydroxychloroquine
 - sulfasalazine
 - leflunomide
 - Other: _____
- Patient has tried and failed two (2) of the following:
 - Cimzia™
 - Remicade®

OR

- Simponi® ARIA™

(Cimzia™, Remicade®, and Simponi® ARIA™ require prior authorization. Forms can be found at www.Optimahealth.com)

Medication being provided by: (Please check applicable box below.)

- Location/site of drug administration: _____
NPI or DEA # of administering location: _____

OR

- Specialty Pharmacy - PropriumRx

****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.

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____