OPTIMA FAMILY CARE MEDALLION 4.0

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

Drug Requested: **Inflectra®** (infliximab-dyyb) **(Q5102)** ***(Medical)***

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

Drug Form/Strength/Quantity: ____

Dosing Schedule: ______________________________ **Length of Therapy**: ______________

Diagnosis: _________________________________ **ICD Code:** ______________

****Medication can only be provided by the Physician's office.****

CLINICAL CRITERIA: ***ALL applicable boxes MUST be checked to ensure the authorization process will NOT be delayed.***

- Prescriber is a**:** ❑ **Gastroenterologist** **OR** ❑ **Rheumatologist**

❑ *Crohn's Disease, Pediatric Crohn's, Ulcerative Colitis*

❑ Failure of budesonide or high dose (40-60mg prednisone) steroids

❑ Patient has tried and failed ***at least one DMARD*** **for at least three (3) months**: ***(Check each that has been tried)***

❑ methotrexate	❑ sulfasalazine	❑ azathioprine
❑ leflunomide	❑ auranofin	❑ hydroxhlorquine
❑ Other ____________________		

❑ Trial and failure of ***two Preferred drugs***:

❑ Remicade®	❑ Entyvio®	❑ Cimzia™

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❑ *Moderate to Severe Chronic Plaque Psoriasis*

❑ Tried and failure of ***two Preferred drugs:***:

❑ Remicade® **AND** ❑ Humira®

OR

❑ Enbrel™

PLUS

❑ **Phototherapy** **OR** ❑ **Alternative Systemic Therapy**

❑ **UV Light Therapy**
- ❑ NB UV-B
- ❑ PUVA
- ❑ cyclosporine

❑ **Oral Alternative Systemic Therapy**
- ❑ acitretin
- ❑ methotrexate

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To qualify, applicable Diagnosis below MUST be checked to ensure the authorization process will NOT be delayed.

❑ **Rheumatoid Arthritis** ❑ **Active Psoriatic Arthritis** ❑ **Ankylosing Spondylitis**

❑ Patient has tried and failed ***at least one DMARD*** **for at least three (3) months**: ***(Check each that has been tried)***

❑ methotrexate	❑ sulfasalazine	❑ azathioprine
❑ leflunomide	❑ auranofin	❑ hydroxhlorquine
❑ Other: ___________________		

❑ Trial and failure of ***two Preferred*** **drugs:**

❑ Remicade® **AND** ❑ Cimzia™

*****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 #: ____________________ Member Date of Birth: ____________

Prescriber Name: ____

Prescriber Signature: ______________________________ Date: ____________

Office Contact Name: ____

Phone Number: ____________________________ Fax Number: ________________

DEA OR NPI #: ____

REVISED/UPDATED: 7/1/2018