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 authorization process. Do not stock pile forms due to changes in criteria.***

Drug Requested: Orencia® (abatacept) **(J-0129)** ***(IV INFUSION ONLY) (Medical)***

DRUG INFORMATION: Complete information below. If incomplete, authorization process will be delayed.

Drug Form/Strength/Month: ______________________________

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

Diagnosis: ______________________ **ICD Code:** ______________

CLINICAL CRITERIA: ALL boxes must be checked to qualify. If not checked, authorization process will be delayed.

- ❑ The prescriber is a Rheumatologist
- ❑ Patient has been diagnosed with ***one*** of the following moderate to severe ***(check below)***:

❑ rheumatoid arthritis	❑ psoriatic arthritis	❑ juvenile idiopathic arthritis

- ❑ Trial and failure of at least a ***90-day trial*** of at least ***one*** previous ***DMARD therapy*** including, but not limited to: ***(check each tried)***

❑ methotrexate	❑ sulfasalazine
❑ azathioprine	❑ leflunomide
❑ auranofin	❑ other ______________
❑ hydroxychloroquine	

AND

- ❑ **Patient has tried and failed *two (2)* of the following biologics:**
  - ❑ Cimzia™
  - ❑ Remicade®
  - ❑ Simponi® ARIA™

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

Medication being provided by (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 #: ______________________________

REVISED/UPDATED: 7/1/2018