

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 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete forms will delay the authorization process.

Drug Requested: **Otrexup™** (methotrexate subcutaneous) (*Non-Preferred*) **(MEDICAID)**

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

Drug Form: _____ Strength: _____
Dosing Schedule: _____ Length of Therapy: _____
Diagnosis: _____ ICD Code, if applicable: _____
Quantity per day: _____

CLINICAL CRITERIA AND DIAGNOSIS: ALL questions below MUST be answered to facilitate processing

- Does the patient meet the following criteria? Yes No
- Diagnosis of active rheumatoid arthritis (RA) or polyarticular juvenile idiopathic arthritis (pJIA) Yes No
 - Therapeutic failure to oral methotrexate? Yes No
 - Patient does not require any of the following methotrexate regimens Yes No
 - Doses less than 10 mg per week,
 - Doses above 25 mg per week,
 - High dose regimens, **OR**
 - Dose adjustments less than 5 mg increments

MEDICAL NECESSITY: Provide clinical evidence below that support the use of the requested medication.

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 #: _____