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.***

Drug Requested: **Rituxan®** (rituximab) **(J9310)** ***(Medical) (Non-Preferred)***

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: Complete below ALL lines for appropriate diagnosis. Authorization process will be delayed if boxes for diagnosis are NOT checked.

DIAGNOSES: Check box that applies. If not complete, authorization process will be delayed.

❑ ***RHEUMATOID ARTHRITIS (RA) INDICATION***

❑ **Prescriber is a Rheumatologist**

AND

❑ Patient has a diagnosis of moderate- to-severe rheumatoid arthritis

AND

❑ Trial and failure of at least three (3) months of methotrexate therapy

AND

❑ Trial and failure of ***two (2)*** of the ***PREFERRED*** biologics below ***(check each tried)***:

❑ Remicade®	❑ Simponi Aria®	❑ Cimzia® IV

❑ ***NON-HODGKIN's LYMPHOMA INDICATION***:

❑ **Prescriber is an Oncologist.**

AND

❑ Patient has a diagnosis of B-cell non-Hodgkin's Lymphoma.

OR

❑ Patient has a diagnosis of CD20-positive Chronic Lymphocytic Leukemia

❑ ***GRANULOMATOSIS with POLYANGIITIS OR MICROSCOPIC POLYANGIITIS INDICATION - INITIAL THERAPY:***

❑ **Prescriber is *(check one that applies):*** ❑ **Rheumatologist** **OR** ❑ **Nephrologist**

AND

❑ Patient has a diagnosis of moderate- to-severe granulomatosis with polyangiitis

AND

❑ Patient will receive concurrent therapy with corticosteroids

AND

❑ Patient failed cyclophosphamide therapy

OR

❑ Patient has a contraindication to cyclophosphamide therapy: _____

_____

(continued on next page)

❑ ***GRANULOMATOSIS with POLYANGIITIS OR MICROSCOPIC POLYANGIITIS INDICATION, MAINTENANCE THERAPY:***

❑ **Prescriber is *(check one that applies):*** ❑ **Rheumatologist** **OR** ❑ **Nephrologist**

AND

❑ Induction occurred at least 4 months prior

AND

❑ Total duration of treatment does not exceed 24 months

AND

❑ Patient failed methotrexate or azathioprine therapy

OR

❑ Patient has a contraindication to methotrexate or azathioprine therapy: _____

_____

Medication being provided by (check applicable box below):

❑ **Physician's office** **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