OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

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. **If information provided is NOT complete, correct, or legible, authorization will be delayed.**

Drug Requested: Humira® (adalimumab) **(PREFERRED)**

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

Drug Form/Strength: ______________________________

Dosing Schedule: **Please enter the dosing below for the diagnosis that applies**.

Length of Therapy: ______________________________

CLINICAL DIAGNOSIS: Check box below that applies. Diagnosis **must** be met for approval. **ALL** documentation, including lab results and/or chart notes **(when required)**, **must** be provided or request will be denied.

❑ Ankylosing Spondylitis (AS) Dosing: ______________________	❑ Crohn's Disease (CD) Dosing: ______________________
❑ Hidradenitis Suppurativa (HS) Dosing: ______________________	❑ Juvenile Idiopathic Arthritis (JIA) Dosing: ______________________
❑ Plaque Psoriasis (Ps) Dosing: ______________________	❑ Psoriatic Arthritis (PsA) Dosing: ______________________
❑ Rheumatoid Arthritis (RA) Dosing: ______________________	❑ Ulcerative Colitis (UC) Dosing: ______________________
❑ Uveitis (UV) Dosing: ______________________	❑ Other: ______________________ Dosing: ______________________

Medication being provided by a Specialty Pharmacy - PropriumRx

(Continued on next page; signature page MUST be attached to request form.)

(Signature page <u>MUST</u> be included with request.)

****Use of samples to initiate therapy <u>does not</u> meet step-edit/preauthorization criteria.****

****<u>Previous therapies will be verified through pharmacy paid claims or submitted chart notes.</u>****

Patient Name: ____

Member Optima #: ______________________________ Date of Birth: ________________

Prescriber Name: ____

Prescriber Signature: ______________________________ Date: ______________

Office Contact Name: ____

Phone Number: ____________________________ Fax Number: ____________________

DEA OR NPI #: ____

REVISED/UPDATED: 6/12/2019