OPTIMA HEATH 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 1-844-348-3720**. 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: Please complete information below or authorization 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: Check box (es) below. **ALL** applicable boxes **MUST** be checked to qualify. If incomplete, authorization process will 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

(continued on next page)

❑ **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. If not checked, authorization process will 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: ~~4/6/2018; 8/22/2018;~~ **10/8/2018**