

# OPTIMA HEALTH COMMUNITY CARE (MEDICAID)

## 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 1-844-348-3720**. 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.**

### Infliximab Category (MEDICAL)

<b>Drug Requested - selected applicable drug below:</b>	
<b>PREFERRED</b>	
<input type="checkbox"/> <b>Renflexis<sup>®</sup></b> (infliximab-abda) (Q5104)	
<b>Non-Preferred</b>	
<input type="checkbox"/> <b>Inflectra<sup>®</sup></b> (infliximab-dyyb) (Q5103)	<input type="checkbox"/> <b>Remicade<sup>®</sup></b> (infliximab) (J1745)

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

Drug Name: \_\_\_\_\_ Form/Strength: \_\_\_\_\_  
 Dosing Schedule: \_\_\_\_\_ Length of Therapy: \_\_\_\_\_  
 Diagnosis: \_\_\_\_\_ ICD Code: \_\_\_\_\_

Effective **February 1, 2019**, Renflexis<sup>®</sup> is the preferred infliximab product. Remicade<sup>®</sup> and Inflectra<sup>®</sup> are non-preferred.

Optima Health members are allowed to continue treatment with Remicade or Inflectra that was authorized prior to February 1<sup>st</sup>, 2019 until the end of their authorization period. At the time of renewal, patients will be required to switch to the preferred product, Renflexis<sup>®</sup>, unless contraindicated.

**\*Medical notes must be submitted to support each line checked on this request.\***

**CLINICAL CRITERIA:** Check applicable boxes below to qualify. Boxes **must** be checked to ensure authorization will **NOT** be delayed.

Prescriber is a:

<input type="checkbox"/> <b>Rheumatologist</b>	<input type="checkbox"/> <b>Dermatologist</b>
<input type="checkbox"/> <b>Gastroenterologist</b>	<input type="checkbox"/> <b>Ophthalmologist</b>

**Member diagnosed with one of the following (indicate which diagnosis):**

<input type="checkbox"/> <b>Rheumatoid Arthritis</b>	<input type="checkbox"/> <b>Ocular Sarcoidosis</b>	<input type="checkbox"/> <b>Ankylosing Spondylitis</b>	<input type="checkbox"/> <b>Plaque Psoriasis</b>
<input type="checkbox"/> <b>Psoriatic Arthritis</b>	<input type="checkbox"/> <b>Crohn's' Disease</b>	<input type="checkbox"/> <b>Ulcerative Colitis</b>	

- Inflectra<sup>®</sup> OR Remicade<sup>®</sup> must have trial and failure of Renflexis<sup>®</sup>**
- Tried and failed **at least one DMARD** therapy for **at least three (3) months** for **ALL** diagnoses **except Plaque Psoriasis**:

<input type="checkbox"/> 6-mercaptopurine	<input type="checkbox"/> methotrexate	<input type="checkbox"/> azathioprine	<input type="checkbox"/> hydroxychloroquine
<input type="checkbox"/> auranofin	<input type="checkbox"/> sulfasalazine	<input type="checkbox"/> leflunomide	<input type="checkbox"/> aminosalicylates
<input type="checkbox"/> Other: _____			

(continued on next page)

**Member diagnosed with Plaque Psoriasis:**

Does member's Psoriasis involve: palms, soles, face, genitalia, or greater than 10% of total body surface area?  Yes **OR**  No

Patient tried and failed **at least one** of either Phototherapy or Alternative Systemic therapy for **at least three (3) months (check each tried)**:

**Phototherapy** **OR**  **Alternative Systemic Therapy:**  
 **UV Light Therapy**  **Oral Alternative System Therapy**

<input type="checkbox"/> NB UV-B	<input type="checkbox"/> acitretin
<input type="checkbox"/> PUVA	<input type="checkbox"/> methotrexate
	<input type="checkbox"/> cyclosporine

**For Crohn's OR Ocular Sarcoidosis disease - moderate to severe with inadequate response to:**

budesonide or high dose steroids (40-60 mg prednisone)

**AND**

DMARD/Immunosuppressive therapy

**For Ulcerative Colitis indication - disease is moderately to severely active with inadequate response to:**

aminosalicylate (table above) **AND**  high dose steroids (40-60 mg prednisone)

**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 #:** \_\_\_\_\_