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. **Incomplete form will delay authorization process.**

Drug Requested: **Kineret™** (anakinra) **(Non-Preferred)**

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

Drug Form/Strength/Quantity: ____

Dosing Schedule: _______________________________ **Length of Therapy:** ________________________

Diagnosis: _____________________________________ **ICD Code, if applicable***:* __________________

CLINICAL CRITERIA: **ALL** boxes **MUST** be checked to qualify to ensure authorization will **NOT** be delayed.

❑ **Prescriber is a Rheumatologist**.

Diagnosis: Moderate to severe Active Rheumatoid Arthritis **ALL** boxes **MUST** be checked to qualify to ensure authorization will **NOT** be delayed.

❑ Patient is at least 18 years old and diagnosed with **moderate to severely active rheumatoid arthritis,**

AND

❑ Trial and failure of, contraindication, or adverse reaction to methotrexate, **AND**

❑ Trial and failure of at least **ONE (1) other DMARD** **(check each tried):**

❑ azathioprine	❑ leflunomide	❑ auranofin	❑ sulfasalazine
❑ hydroxychloroquine	❑ minocycline	❑ Other: ________________________________	

AND

❑ Trial and failure of **ONE (1)** of the **PREFERRED** biologics below:

❑ Humira®	❑ Enbrel®

Diagnosis: Cryopyrin-Associated Periodic Syndromes (CAPS) - **ALL** boxes **MUST** be checked to qualify to ensure authorization will **NOT** be delayed.

❑ Approvable with confirmation of this diagnosis, **AND**

❑ Treatment of Neonatal-Onset Multisystem Inflammatory Disease

(continued from previous page)

Medication being provided by (check applicable box(es) below):

❑ **Physician's office** **OR** ❑ **Specialty Pharmacy: ProprimRx**

*****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***

Patient Name: ____

Member Optima #: ____________________________ Date of Birth: ______________

Prescriber Name: ____

Prescriber Signature: ____________________________ Date: ______________

Office Contact Name: ____

Phone Number: ____________________________ Fax Number: ______________

DEA OR NPI #: ____

REVISED/UPDATED: ~~11/19/2018;~~ **12/9/2018**