OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY 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 1-800-750-9692**. 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: **Olumiant®** (baricitinib) **(Medicaid)**

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

Drug Form/Strength: ______________________________

Dosing Schedule: ______________________ **Length of Therapy:** ______________

Diagnosis: ______________________ **ICD Code:** ______________

CLINICAL CRITERIA: To qualify, **ALL** appropriate boxes below **must** be checked or authorization will be delayed.

- **Prescriber is** a **Rheumatologist**

DIAGNOSIS: Applicable diagnosis below **MUST** be checked to qualify. All chart notes **MUST** be attached to this request or authorization will be delayed.

- ❑ Patient is ≥ 18 years old and
- ❑ Diagnosed with one moderate-to-severe active Rheumatoid Arthritis who have had an inadequate response to one or more tumor necrosis factor (TNF) antagonist therapies

AND

- ❑ Trial and failure of methotrexate

AND

- ❑ Use in combination with other JAK inhibitors, biologic disease-modifying antirheumatic drugs (DMARDs), OR with potent immunosuppressants, such as azathioprine and cyclosporine, is not recommended

AND

- ❑ Trial and failure of Humira® **OR** Enbrel®

Medication being provided by Specialty Pharmacy - PropriumRx

(Continued on next page; Signature page MUST be attached with request form.)

(Signature page MUST be included with request form.)

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: ______________

Prescriber's DEA OR NPI #: ____

***Approved by Pharmacy and Therapeutics Committee**: 10/18/2018
REVISED/UPDATED: 12/13/2018