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 1-844-348-3720**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **Please do not stock pile forms due to changes in criteria**. **Incomplete form will delay authorization process.**

Drug Requested: Orencia® (abatacept) **(J-0129) (IV INFUSION ONLY) (Medical)**

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

Drug Form/Strength/Month: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

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

- ❑ The prescriber is a Rheumatologist
- ❑ Patient has been diagnosed with **one** of the following moderate to severe **(check below):**

❑ rheumatoid arthritis	❑ psoriatic arthritis	❑ juvenile idiopathic arthritis

- ❑ Trial and failure of at least a **90-day trial** of at least **one** previous **DMARD therapy** including, but not limited to: **(check each tried)**

❑ methotrexate	❑ sulfasalazine
❑ azathioprine	❑ leflunomide
❑ auranofin	❑ other _____
❑ hydroxychloroquine	

AND

- ❑ **Patient has tried and failed *two (2)* of the following biologics:**
  - ❑ Cimzia™ ❑ Remicade® ❑ Simponi® ARIA™

(Cimzia™, Remicade®, and Simponi® ARIA® require Prior Authorization.
Forms can be found at www.Optimahealth.com/providers/pharmacy/drug-authorization-forms)

Medication being provided by (check applicable box below):

- ❑ **Location/site of drug administration:** _____

  NPI or DEA # of administering location: _____

  OR

- ❑ **Physician's office** **OR** ❑ **Specialty Pharmacy – PropriumRx**

(Continued on next page; signature page MUST be attached with this request.)

(Signature page MUST be included with this request.)

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 #: _____

REVISED/UPDATED: ~~8/1/2017~~; ~~12/20/2017~~; ~~6/4/2018~~; ~~8/28/2018~~; **10/8/2018**;