

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.

Diagnosis - check applicable diagnosis below:

Moderate to severe Active Rheumatoid Arthritis (RA)

- The prescriber is a Rheumatologist
- Patient has been diagnosed with moderate to severe rheumatoid arthritis; **AND**
- Trial and failure of, contraindication, or adverse reaction to methotrexate, **AND**
- Trial and failure of at least **ONE (1)** other **DMARD therapy** including, but not limited to: (**check each tried**)

<input type="checkbox"/> auranofin	<input type="checkbox"/> sulfasalazine
<input type="checkbox"/> azathioprine	<input type="checkbox"/> leflunomide
<input type="checkbox"/> hydroxychloroquine	<input type="checkbox"/> other _____

AND

- Patient has tried and failed ONE (1) of the following biologics:**
- Humira® **OR** Enbrel®

Juvenile Idiopathic Arthritis (JIA):

- The prescriber is a Rheumatologist
- Patient has been diagnosed with moderate to severe active Juvenile Idiopathic Arthritis (JIA); **AND**
- Trial and failure of, contraindication, or adverse reaction to methotrexate, **AND**
- Trial and failure of at least **ONE (1)** other **DMARD therapy** including, but not limited to: (**check each tried**):

(continued on next page)

(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: 8/4/2017; 12/20/2017; 6/4/2018; 8/28/2018; 10/8/2018; **12/9/2018**