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. **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)**

❑ auranofin	❑ sulfasalazine
❑ azathioprine	❑ leflunomide
❑ hydroxychloroquine	❑ 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)

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

AND

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

❑ Humira® **OR** ❑ Enbrel®

❑ Active Psoriatic Arthritis (PsA):

❑ The prescriber is a **Rheumatologist**

❑ Patient has been diagnosed with **moderate to severe active Psoriatic Arthritis (PsA)**; **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)**:

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

AND

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

❑ Humira® **OR** ❑ Enbrel®

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**

(Signature page is on the next page and MUST be attached to this request form.)

(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~~; ~~12/9/2018~~; **(Reformatted) 2/6/2019**;