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 forms will delay the authorization process**.

Drug Requested: Otrexup™ (methotrexate subcutaneous) **(Non-Preferred)**

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

Drug Form/Strength: _____

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

Diagnosis: _____ **ICD Code, if applicable:** _____

Quantity per Day: _____

CLINICAL CRITERIA AND DIAGNOSES: **ALL** questions below **MUST** be answered to facilitate processing to ensure authorization will **NOT** be delayed. Check diagnosis that applies.

DIAGNOSIS – Active Rheumatoid Arthritis (RA)

LENGTH OF AUTHORIZATION: 6 months, then renew for 1 year, if compliant and appropriate monitoring occurs.

- ❑ Has had therapeutic failure to **two (2)** **Preferred DMARD** agents; **AND**
- ❑ Must have allergy or contraindication to benzoyl alcohol or other preservative contained in generic injectable methotrexate

DIAGNOSIS – Polyarticular Juvenile Idiopathic Arthritis (pJIA)

- ❑ Has had therapeutic failure to **two (2)** **Preferred NSAIDS** agents; **AND**
- ❑ Must have allergy or contraindication to benzoyl alcohol or other preservative contained in generic injectable methotrexate

DIAGNOSIS – Psoriasis

LENGTH OF AUTHORIZATION: 6 months

- ❑ A therapeutic trial and failure on topical therapies such as topical emollients and/or topical corticosteroids, topical retinoids, topical vitamin D analogs, and topical tacrolimus, AND pimecrolimus; **AND**
- ❑ Must have allergy or contraindication to benzoyl alcohol or other preservative contained in generic injectable methotrexate.

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

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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: ~~7/2/2017;~~ ~~8/31/2017;~~ ~~8/29/2018;~~ **12/9/2018**;