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**. Incomplete form will delay authorization process.**

Drug Requested: **Remicade®** (Infliximab) **(J-1745) (Medical)**

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

Drug Form/Strength/Month: _____

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

Diagnosis: _____ **ICD Code:** _____

****Medical notes must be submitted to support each line checked on this request.****

CLINICAL CRITERIA: Check applicable boxes below to qualify. Boxes **must** be checked to ensure authorization will **NOT** be delayed**.**

Prescriber is a: ❑ **Rheumatologist** ❑ **Dermatologist** ❑ **Gastroenterologist**

Member diagnosed with one of the following (indicate which diagnosis):

❑ **Rheumatoid Arthritis**	❑ **Ocular Sarcoidosis**	❑ **Ankylosing Spondylitis**	❑ **Plaque Psoriasis**
❑ **Psoriatic Arthritis**	❑ **Crohn's' Disease**	❑ **Ulcerative Colitis**	

❑ Tried and failed **at least one DMARD** therapy for **at least three (3) months** for **ALL** diagnoses **EXCEPT Plaque Psoriasis**:

❑ 6-mercaptopurine	❑ methotrexate	❑ azathioprine	❑ hydroxychloroquine
❑ auranofin	❑ sulfasalazine	❑ leflunomide	❑ aminosalicylates
❑ Other: _____			

Member diagnosed with Plaque Psoriasis:

❑ Does member's Psoriasis involve: palms, soles, face, genitalia, or greater than 10% of total body surface area?
❑ Yes **OR** ❑ No

(continued on next page)

- ❑ Patient tried and failed **at least one** of either Phototherapy or Alternative Systemic therapy for **at least three (3) months (check each tried):**

❑ **Phototherapy** **OR** ❑ **Alternative Systemic Therapy**:

❑ **UV Light Therapy** ❑ **Oral Alternative System Therapy**

❑ NB UV-B	❑ acitretin
❑ PUVA	❑ methotrexate
	❑ cyclosporine

For Crohn's OR Ocular Sarcoidosis disease - moderate to severe with inadequate response to:

- ❑ budesonide or high dose steroids (40-60 mg prednisone)

AND

- ❑ DMARD/Immunosuppressive therapy

For Ulcerative Colitis indication - disease is moderately to severely active with inadequate response to:

❑ aminosalicylate (table above) **AND** ❑ high dose steroids (40-60 mg prednisone)

Medication being provided by (check applicable box below):

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

NPI or DEA # of administering location: _____

OR

❑ **Specialty Pharmacy**: ❑ **PropriumRx** **OR** ❑ **Sentara Norfolk General CM Pharmacy**

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 #: _____

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