

# OPTIMA HEALTH 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 1-844-723-2094. 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:** Rituxan<sup>®</sup> (rituximab) (J9310) (Medical) (Non-Preferred)  
(for Pemphigus Vulgaris)

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

**Drug Form/Strength/Month:** \_\_\_\_\_

**Dosing Schedule:** \_\_\_\_\_ **Length of Therapy:** \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_ **ICD Code:** \_\_\_\_\_

**CLINICAL CRITERIA:** Complete information below to ensure authorization will **NOT** be delayed.

- Patient has a confirmed diagnosis of moderate- to-severe Pemphigus Vulgaris within the previous 24 months based on histological features of acantholysis via skin or mucosal biopsy and one of the following:
  - Tissue bound immunoglobulin G (IgG) antibodies against epithelial cell surface, **OR**
  - Serological detection of serum desmoglein-3 (DSg3) autoantibodies against epithelial cell surface either by indirect immunofluorescence microscopy or by enzyme-linked immunosorbent assay
- Presence of moderate-to-severely active disease, defined as overall PDAI activity score of greater than or equal to (>=)15; **AND**
- Patient has been receiving standard-of-care corticosteroids consisting of 60-120mg/day oral prednisone or equivalent for at least 60 days (**within the past 90 days**)

**Medication being provided by (check applicable box below):**

**Location/site of drug administration:** \_\_\_\_\_

**NPI or DEA # of administering location:** \_\_\_\_\_

**OR**

**Specialty Pharmacy: PropriumRx**

(Signature on next 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 #: \_\_\_\_\_

\*Approved by the Pharmacy and Therapeutic Committee: 6/15/2006

REVISED/UPDATED: 10/11/2018; (REFORMATTED) 2/5/2019