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

Drug Requested: Rituxan® (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: ~~10/1/2018;~~ **(REFORMATTED) 2/5/2019**