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®** (rituximab) **(J9310) (Medical) (Non-Preferred)**

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 below **ALL** lines for appropriate diagnosis. Authorization might be delayed if boxes for diagnosis are **NOT** checked.

DIAGNOSES: **Check box that applies to ensure authorization will NOT be delayed.**

❑ RHEUMATOID ARTHRITIS (RA) INDICATION

- ❑ **Prescriber is a Rheumatologist**

AND

- ❑ Patient has a diagnosis of moderate- to-severe rheumatoid arthritis

AND

- ❑ Trial and failure of at least three (3) months of methotrexate therapy

AND

- ❑ Trial and failure of **two (2)** of the **PREFERRED** biologics below **(check each tried)**:

❑ Remicade®	❑ Simponi Aria®	❑ Cimzia® IV

❑ NON-HODGKIN's LYMPHOMA INDICATION:

- ❑ **Prescriber is an Oncologist.**

AND

- ❑ Patient has a diagnosis of B-cell non-Hodgkin's Lymphoma.

OR

- ❑ Patient has a diagnosis of CD20-positive Chronic Lymphocytic Leukemia

❑ GRANULOMATOSIS with POLYANGIITIS OR MICROSCOPIC POLYANGIITIS INDICATION - INITIAL THERAPY:

- ❑ **Prescriber is (check one that applies):** ❑ **Rheumatologist** **OR** ❑ **Nephrologist**

AND

- ❑ Patient has a diagnosis of moderate- to-severe granulomatosis with polyangiitis

AND

- ❑ Patient will receive concurrent therapy with corticosteroids

AND

- ❑ Patient failed cyclophosphamide therapy

OR

- ❑ Patient has a contraindication to cyclophosphamide therapy: _____

_____

❑ GRANULOMATOSIS with POLYANGIITIS OR MICROSCOPIC POLYANGIITIS INDICATION, MAINTENANCE THERAPY:

- ❑ **Prescriber is (check one that applies):** ❑ **Rheumatologist** **OR** ❑ **Nephrologist**

AND

- ❑ Induction occurred at least 4 months prior

AND

- ❑ Total duration of treatment does not exceed 24 months

AND

- ❑ Patient failed methotrexate or azathioprine therapy

OR

- ❑ Patient has a contraindication to methotrexate or azathioprine therapy: _____

_____

Medication being provided by (check applicable box below):

❑ **Physician's office** **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 #: _____

REVISED/UPDATED: ~~8/1/2017; 8/31/2017; 12/28/2017;;8/29/2018; 10/1/2018;~~ **(REFORMATTED) 2/5/2019**