

**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: **Xeljanz[®]** (tofacitinib)/**Xeljanz[®] XR[®]** (tofacitinib xr) (**Non-Preferred**)

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

Dosage Form/Strength: _____

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

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

Quantity per Day: _____

CLINICAL CRITERIA: **ALL** appropriate lines **must** be checked to qualify to ensure authorization s will **NOT** be delayed.

- Is Xeljanz[®] being used for the treatment of moderately to severely active rheumatoid arthritis? Yes No
- Has the patient had an inadequate response to or intolerance to methotrexate? Yes No

Provide details: _____

- Has the patient had a therapeutic trial and treatment failure with at least **ONE (1) Preferred** drug (i.e. Enbrel[®] or Humira[®])?

Yes No

Provide details: _____

- Is the patient currently using any biologic DMARDs or potent immunosuppressants (i.e. sulfasalazine, hydroxychloroquine, minocycline)? Yes No

If Yes, please explain: _____

Medication being provided by a Specialty Pharmacy - PropriumRx

(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:** 6/30/2017; 9/1/2017; 9/4/2018; 12/9/2018