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. azathioprine, cyclosporine)? ❑ 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.)

(Signature page MUST be attached to 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:** ~~6/30/2017; 9/1/2017;~~ **9/1/2018**;