OPTIMA HEALTH COMMUNITY CARE

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 1-800-319-5003. 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: Actemra® SQ (tocilizumab) ***(self-administered) (Pharmacy) (Non-Preferred)***

DRUG INFORMATION: Complete information below. If incomplete, authorization process will be delayed

Drug Form/Strength: _____

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

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

CLINICAL CRITERIA: ALL boxes MUST be checked to qualify. Incomplete information will delay authorization process.

- ❑ Prescriber is a Rheumatologist
- ❑ Patient has moderate to severe rheumatoid arthritis
- ❑ Trial and failure of ***at least one DMARD*** for at least three (3) months ***(check each tried)***:

❑ methotrexate	❑ sulfasalazine	❑ azathioprine
❑ leflunomide	❑ auranofin	❑ hydroxychloroquine
❑ Other: _____		

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

❑ Humira®	❑ Cimzia® SQ	❑ Simponi®

(Prior Authorization forms can be found at: www.Optimahealth.com)

Medication being provided by (check applicable box below):

❑ **Physician's office** **OR** ❑ **Specialty Pharmacy**: **PropriumRx**

*****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 #: _____

UPDATED/REVISED: 4/6/2018