

To qualify, applicable Diagnosis below **MUST** be checked. If **not** checked, authorization process will be delayed.

- Rheumatoid Arthritis** **Active Psoriatic Arthritis** **Ankylosing Spondylitis**

- Patient has tried and failed **at least one DMARD** for at **least three (3) months**: (*Check each that has been tried*)

<input type="checkbox"/> methotrexate	<input type="checkbox"/> sulfasalazine	<input type="checkbox"/> azathioprine
<input type="checkbox"/> leflunomide	<input type="checkbox"/> auranofin	<input type="checkbox"/> hydroxhlorquine
<input type="checkbox"/> Other: _____		

- Trial and failure of **two Preferred drugs**:

- Remicade® **AND** Cimzia™

****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 #: _____ Member Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

REVISED/UPDATED: 4/6/2018