

OPTIMA HEALTH COMMUNITY CARE

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 1-844-348-3720. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Please do not stock pile forms due to changes in criteria.

Drug Requested: Orencia® (abatacept) (J-0129) **(IV INFUSION ONLY)** (Medical)

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

Drug Form/Strength/Month: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code: _____

CLINICAL CRITERIA: ALL boxes must be checked to qualify. If not checked, authorization process will be delayed.

- The prescriber is a Rheumatologist
- Patient has been diagnosed with one of the following moderate to severe (**check below**):

<input type="checkbox"/> rheumatoid arthritis	<input type="checkbox"/> psoriatic arthritis	<input type="checkbox"/> juvenile idiopathic arthritis
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- Trial and failure of at least a 90-day trial of at least one previous DMARD therapy including, but not limited to: (**check each tried**)

<input type="checkbox"/> methotrexate	<input type="checkbox"/> sulfasalazine
<input type="checkbox"/> azathioprine	<input type="checkbox"/> leflunomide
<input type="checkbox"/> auranofin	<input type="checkbox"/> other _____
<input type="checkbox"/> hydroxychloroquine	

AND

- Patient has tried and failed two (2) of the following biologics:
- Cimzia™ Remicade® Simponi® ARIA™

(Cimzia™, Remicade®, and Simponi ARIA® require 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 #: _____