OPTIMA HEALTH PLAN

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 forms will delay the authorization process.***

Drug Requested: **Otrexup™** (methotrexate subcutaneous) ***(Non-Preferred)*** **MEDICAID**

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:*** _____

Quantity per day: _____

CLINICAL CRITERIA AND DIAGNOSIS: ***ALL questions below MUST be answered to facilitate processing***

Does the patient meet the following criteria? ❑ Yes ❑ No

- Diagnosis of active rheumatoid arthritis (RA) or polyarticular juvenile idiopathic arthritis (pJIA) ❑ Yes ❑ No
- Therapeutic failure to oral methotrexate? ❑ Yes ❑ No
- Patient ***does not*** require any of the following methotrexate regimens ❑ Yes ❑ No
  - Doses less than 10 mg per week,
  - Doses above 25 mg per week,
  - High dose regimens, **OR**
  - Dose adjustments less than 5 mg increments

MEDICAL NECESSITY: ***Provide clinical evidence below that support the use of the requested medication.***

_____

_____

_____

_____

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: ~~7/2/2017;~~ **8/31/2017**