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. Incomplete form will delay authorization process.***

Drug Requested: **Remicade®** (Infliximab) **(J-1745)** ***(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:** _____

*****Medical notes must be submitted to support each line checked on this request.*****

CLINICAL CRITERIA: Check applicable boxes below. To qualify, boxes must be checked or authorization process will be delayed.

Prescriber is a: ❑ **Rheumatologist** ❑ **Dermatologist** ❑ **Gastroenterologist**

- Patient has a diagnosis of one of the following ***(indicate which diagnosis)***:
  - ❑ ***Rheumatoid Arthritis*** ❑ ***Ocular Sarcoidosis*** ❑ ***Ankylosing Spondylitis*** ❑ ***Plaque Psoriasis***
  - ❑ ***Psoriatic Arthritis*** ❑ ***Crohn's' Disease*** ❑ ***Ulcerative Colitis***
- Patient has tried and failed ***at least one DMARD*** therapy for ***at least three (3) months*** for ***ALL*** diagnosis ***except Plaque Psoriasis***:
  - ❑ 6-mercaptopurine ❑ methotrexate ❑ azathioprine ❑ hydroxychloroquine ❑ auranofin
  - ❑ sulfasalazine ❑ leflunomide ❑ aminosalicylates ❑ Other: _____
- For ***Plaque Psoriasis***:

  Does the member's Psoriasis involve: palms, soles, face, genitalia, or greater than 10% of total body surface area?

  ❑ Yes **OR** ❑ No
- Tried and failure of:
  - ❑ **Phototherapy**
    - ❑ **UV Light Therapy**
      - ❑ NB UV-B
      - ❑ PUVA

  OR

  - ❑ **Alternative Systemic Therapy**:
    - ❑ **Oral Alternative System Therapy**
      - ❑ acitretin
      - ❑ methotrexate
      - ❑ cyclosporine
- For ***Crohn's OR Ocular Sarcoidosis disease*** - moderate to severe with inadequate response to:

  ❑ budesonide or high dose steroids (40-60 mg prednisone) **AND** ❑ DMARD/Immunosuppressive therapy
- For ***Ulcerative Colitis*** indication, disease is moderately to severely active with inadequate response to:

  ❑ aminosalicylate (table above) **AND** ❑ high dose steroids (40-60 mg prednisone)

(signature on next page)

***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 #: _____

REVISED/UPDATED: ~~8/1/2017;~~ **9/2/2017**;