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 forms will delay the authorization process.***

Drug Requested: Xeljanz® (tofacitinib)**/Xeljanz® XR®** (tofacitinib xr) ***(Non-Preferred)*** **MEDICAID**

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

Dosage Form/Strength: _____

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

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

Quantity per Day: _____

CLINICAL CRITERIA: ALL appropriate lines must be checked to qualify or authorization process will be delayed.

- Is Xeljanz® being used for the treatment of moderately to severely active rheumatoid arthritis? ❑ Yes ❑ No
- Has the patient had an inadequate response to or intolerance to methotrexate? ❑ Yes ❑ No
  Provide details: _____
  _____
- Has the patient had a therapeutic trial and treatment failure with at least **ONE (1) Preferred** drug (i.e. Enbrel® or Humira®)?
  ❑ Yes ❑ No
  Provide details: _____
  _____
- Is the patient currently using any biologic DMARDs or potent immunosuppressants (i.e. azathioprine, cyclosporine)?
  ❑ Yes ❑ No
  If Yes, please explain: _____

_____

_____

Medication being provided by a 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:** ~~6/30/2017;~~ **9/1/2017**;