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 1-800-750-9692. 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: Enbrel® (etanercept) **(J-1438)**

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:*** _____

CLINICAL CRITERIA: ALL boxes MUST be checked to qualify. Incomplete information will delay authorization process.

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

Diagnosis:
- ❑ **Rheumatoid Arthritis**
- ❑ **Active Psoriatic Arthritis**
- ❑ **Ankylosing Spondylitis**
- ❑ **Juvenile idiopathic arthritis**

AND

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

❑ methotrexate	❑ azathioprine	❑ hydroxychloroquine
❑ sulfasalazine	❑ leflunomide	❑ auranofin
❑ Other: _____		

OR

Diagnosis: ❑ **Moderate to Severe Chronic Plaque Psoriasis**

❑ Tried and failure of:

❑ **Phototherapy** **OR** ❑ **Alternative Systemic Therapy**

- ❑ **UV Light Therapy Systemic Therapy**
  - ❑ NB UV-B
  - ❑ PUVA
- ❑ **Oral Alternative**
  - ❑ acitretin
  - ❑ methotrexate
  - ❑ cyclosporine

(signature on next page)

Medication being provided by** (check applicable box(es) below)**:

- ❑ **Physician's office**
  OR
- ❑ **Specialty Pharmacy**: ❑ **Briova SpecialtyRx**

*****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 #: _____

***Approved by Pharmacy & Therapeutics Committee**: 9/17/2009
REVISED/UPDATED: ~~6/3/2011; 8/12/2011; 1/16/2014; 2/5/2014; 2/25/2014; 4/3/2014; 4/28/2014; 5/2/2014; 8/8/2014; 10/30/2014; 5/21/2015; 12/27/2015; 8/12/2016; 9/22/2016; 11/17/2016; 12/12/2016; 9/14/2017;~~ **10/6/2017**