# OPTIMA HEALTH PLAN

## 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 1-844-202-5034. 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:** **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 moderate to severe rheumatoid arthritis
- ❑ Patient has tried and failed at least ***one previous DMARD therapy*** including, but not limited to: ***(Check each that has been tried)***

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

- ❑ **Patient has tried and failed two (2) TNFs:**
  - ❑ Enbrel® **OR** ❑ Humira® **AND** ❑ Remicade® **OR** ❑ Simponi® ARIA™

**AND**

- ❑ **Patient has tried and failed:** ❑ Xeljanz®/Xeljanz® XR

***(Enbrel™, Remicade® and Humira® require Prior Authorization. Form can be found at www.Optimahealth.com)***

***Medication being provided by (check applicable box 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 and Therapeutics Committee**: 2/16/2006

**REVISED/UPDATED:** ~~6/3/2011; 8/22/2011; 4/19/2012; 7/11/2012; 10/1/2012; 1/16/2014; 1/27/2014; 2/5/2014; 4/28/2014; 8/8/2014; 10/31/2014; 11/21/2014; 4/3/2015; 5/23/2015; 1/29/2016; **3/31/2016**; 8/18/2016; 9/22/2016; 11/29/2016; 12/13/2016; 9/16/2017;~~ **10/4/2017**