OPTIMA HEALTH PLAN

PHARMACY/MEDICAL PRIOR AUTHORIZATION 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® IV(abatacept) **(J-0129)** ***(IV INFUSION ONLY)*** ***(Medical)***

DRUG INFORMATION*: *Complete information below or 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 to ensure authorization will NOT be delayed.

- ❑ The prescriber is a **Rheumatologist**
- ❑ Patient has been diagnosed with ***one*** of the following moderate to severe ***(check below):***

❑ rheumatoid arthritis	❑ psoriatic arthritis	❑ juvenile idiopathic arthritis

- ❑ Patient has tried and failed at least ***one previous DMARD therapy*** including, but not limited to: ***(check each tried)***

❑ methotrexate	❑ sulfasalazine
❑ azathioprine	❑ leflunomide
❑ auranofin	❑ other _____
❑ hydroxychloroquine	

AND

- ❑ **Patient has tried and failed *two (2)* of the following biologics:**
  - ❑ Cimzia™ IV ❑ Remicade® ❑ Simponi ARIA®

(Cimzia™, Remicade®, and Simponi ARIA® require Prior Authorization. Forms can be found at www.Optimahealth.com)

Medication being provided by (check applicable box below):

- ❑ **Location/site of drug administration:** _____
  NPI or DEA # of administering location: _____

OR

- ❑ **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: 7/10/2018