

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: (select drug below)

<input type="checkbox"/> Otrexup™ (methotrexate subcutaneous)	<input type="checkbox"/> Rasuvo® (methotrexate subcutaneous)
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DRUG INFORMATION: Complete information below. Authorization process will be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

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

- Has the member tried and failed one of the following?
 - methotrexate IV
 - methotrexate tablets

****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: 10/15/2015
REVISED/UPDATED: 10/29/2015; 12/22/2015; 12/19/2016; 9/22/2017.