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 and 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: **Rayos**® (prednisone delayed-release)

DRUG INFORMATION: Complete information below. Authorization process will be delayed if incomplete.

Drug Form/Strength: ______________________________

Dosing Schedule: ______________________ **Length of Therapy**: ______________

Diagnosis: ______________________ ***ICD Code, if applicable***: ______________

CLINICAL CRITERIA: ALL appropriate boxes must be checked to qualify or authorization process will be delayed. Chart notes documenting diagnosis and therapeutic failure MUST be attached to this request.

- ❑ Patient has a diagnosis of rheumatoid arthritis (please submit chart notes documenting diagnosis)

AND

- ❑ Patient has tried and failed 30 days of therapy with prednisone tablets (please submit chart notes documenting therapeutic failure)

AND

- ❑ Patient has tried and failed 30 days of therapy with dexamethasone (please submit chart notes documenting therapeutic failure)

AND

- ❑ Patient has tried and failed 30 days of therapy with methylprednisolone (please submit chart notes documenting therapeutic failure)

*****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:** 10/16/2014
REVISED/UPDATED: ~~10/28/2014; 5/22/2015; 9/15/2016; 11/14/2016; 12/12/2016;~~ **9/22/2017**;