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: **Remicade®** (Infliximab) **(J-1745)** ***(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:** _____

*****Medical notes must be submitted to support each line checked on this request.*****

CLINICAL CRITERIA: Check applicable boxes below to qualify. Boxes must be checked or authorization process will be delayed.

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

- Patient has a diagnosis of one of the following ***(indicate which diagnosis)*****:**
  - ❑ **Rheumatoid Arthritis** ❑ **Ocular Sarcoidosis** ❑ **Ankylosing Spondylitis** ❑ **Plaque Psoriasis**
  - ❑ **Psoriatic Arthritis** ❑ **Crohn's' Disease** ❑ **Ulcerative Colitis**
- Patient has tried and failed ***at least one* DMARD** therapy for ***at least three (3) months*** for ***ALL*** diagnosis ***except Plaque Psoriasis***:

❑ 6-mercaptopurine	❑ methotrexate	❑ azathioprine	❑ auranofin
❑ hydroxychloroquine	❑ sulfasalazine	❑ leflunomide	❑ aminosalicylates
❑ Other			

- For ***Plaque Psoriasis*****:**

  Does the member Psoriasis involves: palms, soles, face, genitalia, or greater than 10% of total body surface area?

  ❑ Yes **OR** ❑ No

  - **Trial and failure of:**

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

    ❑ **UV Light Therapy**
    - ❑ NB UV-B
    - ❑ PUVA

    ❑ **Oral Alternative System Therapy**
    - ❑ acitretin
    - ❑ methotrexate
    - ❑ cyclosporine

  - For ***Crohn's or Ocular Sarcoidosis disease*** is moderate to severe with inadequate response to:

    ❑ budesonide or high dose steroids (40-60 mg prednisone) **AND** ❑ DMARD/Immunosuppressive therapy

  - For ***Ulcerative Colitis*** indication, disease is moderately to severely active with inadequate response to:

    ❑ aminosalicylate (table above) **AND** ❑ high dose steroids (40-60 mg prednisone)

(signature on next page)

***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 & Therapeutic Committee:**
REVISED/UPDATED: ~~2/4/2010~~; ~~6/3/2011~~; ~~8/30/2011~~; ~~4/23/2012~~; ~~1/16/2014~~; ~~2/4/2014~~; ~~4/4/2014~~; ~~4/28/2014~~; ~~8/13/2014~~; ~~10/31/2014~~; ~~4/3/2015~~; ~~5/23/2015~~; ~~12/30/2015~~; ~~1/29/2016~~; ~~8/18/2016~~; ~~9/22/2016~~; ~~11/29/2016~~; ~~12/13/2016~~; ~~9/16/2017~~; **10/8/2017**