

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: Rituxan® (rituximab) (J9310) (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: Complete below **ALL** lines for appropriate diagnosis. Authorization process will be delayed if boxes for diagnosis are **NOT** checked.

RHEUMATOID ARTHRITIS (RA) INDICATION:

- Prescriber is a Rheumatologist
AND
- Patient has a diagnosis of moderate- to-severe rheumatoid arthritis
AND
- Patient has failed methotrexate therapy and all other forms of therapy.
AND
- Patient has tried and failed **two (2):**
 - Humira® **OR** Enbrel™
 - AND** Remicade®**AND**
- Patient has tried and failed:
 - Xeljanz®/Xeljanz® XR

NON-HODGKIN'S LYMPHOMA INDICATION:

- Prescriber is an Oncologist.
AND
- Patient has a diagnosis of B-cell non-Hodgkin's Lymphoma.
OR
- Patient has a diagnosis of CD20-positive Chronic Lymphocytic Leukemia

GRANULOMATOSIS with POLYANGIITIS OR MICROSCOPIC POLYANGIITIS INDICATION, INITIAL THERAPY:

- Prescriber is a Rheumatologist or Nephrologist
AND
- Patient has a diagnosis of moderate- to-severe granulomatosis with polyangiitis
AND
- Patient will receive concurrent therapy with corticosteroids
AND
- Patient has failed cyclophosphamide therapy
OR
- Patient has a contraindication to cyclophosphamide therapy:

GRANULOMATOSIS with POLYANGIITIS OR MICROSCOPIC POLYANGIITIS INDICATION, MAINTENANCE THERAPY:

- Prescriber is a Rheumatologist or Nephrologist
AND
- Induction occurred at least 4 months prior
AND
- Total duration of treatment does not exceed 24 months
AND
- Patient has failed methotrexate or azathioprine therapy
OR
- Patient has a contraindication to methotrexate or azathioprine therapy:

(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 the Pharmacy and Therapeutic Committee: 6/15/2006

REVISED/UPDATED: 7/17/2010; 6/3/2011; 9/7/2011; 4/24/2012; 10/1/2012; 8/13/2014; 10/31/2014; 4/3/2015; 5/23/2015; 12/30/2015; 1/29/2016; 3/30/2016; 9/20/2016; 11/29/2016; 12/13/2016; 9/16/2017; 10/4/2017;