

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: Actemra® SQ (tocilizumab) (self-administered) (Pharmacy)

DRUG INFORMATION: Complete information below. If incomplete, authorization process will be delayed

Drug Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

CLINICAL CRITERIA: ALL boxes MUST be checked to qualify. Incomplete information will delay authorization process.

- The prescriber is a Rheumatologist
- Patient has moderate to severe rheumatoid arthritis
- Patient has tried and failed at least one previous DMARD therapy including, but not limited to (*check each that has been tried*):
 - methotrexate
 - azathioprine
 - auranofin
 - hydroxychloroquine
 - sulfasalazine
 - leflunomide
 - Other: _____
- Patient has tried and failed **all** of the following:
 - Enbrel®
 - Humira®
 - Xeljanz® / Xeljanz® XR

(Enbrel™, Humira®, and Xeljanz® / Xeljanz® XR require Prior Authorization.

Form can be found at: www.Optimahealth.com)

Medication being provided by (check applicable box below):

- Physician's office
- OR
- Specialty Pharmacy: _____
- PropriumRx

****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: 6/17/2010

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