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; **(Pharmacy) 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: D-Penamine® (penicillamine)

DRUG INFORMATION: Complete information below or authorization will be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

CLINICAL CRITERIA: Check below **ALL** that apply. **ALL** criteria **must** be met for approval. **ALL** documentation including labs or chart notes (if required) **must** be submitted or request will be denied.

Diagnoses: Check the diagnosis below that applies. **ALL** criteria **must** be met for approval.

Initial authorization for approval for Wilson's Disease: ALL criteria **must** be met to qualify for initial 3-month approval. Chart notes must be submitted for documentation.

- ❑ Patient **must** have diagnosis of Wilson's disease

AND

- ❑ Medication **must** be prescribed by or in consultation with a gastroenterologist or hepatologist

AND

- ❑ Diagnosis was confirmed by one of the following (please submit labs or chart notes for documentation):
  - ❑ Presence of Kayser-Fleisher rings
  - ❑ Serum ceruloplasmin (CPN) <20mg/dL
  - ❑ 24-hour urine copper > 40 mcg
  - ❑ Liver biopsy with copper dry weight > 250 mcg/g

AND

- ❑ Dose will not exceed 1.5gm/day

Reauthorization for Wilson's Disease: ALL criteria **must** be met to qualify for continued 12-month approval. Labs must be submitted for documentation.

- ❑ Patient's serum copper level is <10 mcg free copper/dL of serum

AND

- ❑ Dose will not exceed 1.5gm/day

(Continued on next page)

Initial authorization for Cystinuria: ALL criteria **must** be met to qualify for initial 6-month approval. Chart notes must be submitted for documentation.

- ❑ Patient **must** have diagnosis of cystinuria

AND

- ❑ Medication **must** be prescribed by or in consultation with a nephrologist or metabolic geneticist

AND

- ❑ Patient must have urinary cystine excretion of >300mg/day

AND

- ❑ Patient must have had 30-day trial and failure of potassium citrate or other urinary alkalinizing agent along with sodium and protein-restricted diet and hyperdiuresis (urine output of at least 3L/day)

AND

- ❑ Dose will not exceed 4gm/day

Reauthorization for Cystinuria: ALL criteria **must** be met to qualify for continued 12-month approval. Labs must be submitted for documentation.

- ❑ Patient must have urinary cystine excretion of <200mg/day

AND

- ❑ Dose will not exceed 4gm/day

Initial authorization for severe active Rheumatoid Arthritis: ALL criteria **must** be met to qualify for initial 6-month approval. Chart notes must be submitted for documentation.

- ❑ Patient must have a diagnosis of severe active Rheumatoid Arthritis

AND

- ❑ Medication **must** be prescribed by or in consultation with a rheumatologist

AND

- ❑ Patient has had 30-day trial and failure of 2 of the following: Humira®, Cimzia® or Simponi®

AND

- ❑ Dose will not exceed 250mg/day for the first month and 1.5gm/day for maintenance therapy

Reauthorization for severe active Rheumatoid Arthritis: ALL criteria **must** be met to qualify for continued 6-month approval. Chart notes must be submitted for documentation.

- ❑ Patient must have shown a clinically significant improvement in rheumatoid arthritis symptoms with chart notes documenting improvement in symptoms

(Continued on next page; Signature page must be attached to this request form)

(Signature page must be included with form)

Medication being provided by 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**: 1/17/2019
REVISED/UPDATED: 3/6/2019