

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: **Enbrel® (etanercept) (Non-Preferred)**

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.

Prescriber is a: Rheumatologist Dermatologist

DIAGNOSIS: Applicable diagnosis below MUST be checked to qualify. All chart notes MUST be attached to this request or authorization process will be delayed.

<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Active Psoriatic Arthritis
<input type="checkbox"/> Ankylosing Spondylitis	<input type="checkbox"/> Juvenile idiopathic arthritis

Trial and failure of at least one DMARD for at least three (3) months (check each tried):

<input type="checkbox"/> methotrexate	<input type="checkbox"/> azathioprine	<input type="checkbox"/> hydroxychloroquine
<input type="checkbox"/> sulfasalazine	<input type="checkbox"/> leflunomide	<input type="checkbox"/> auranofin
<input type="checkbox"/> Other: _____		

AND

Trial and failure of two (2) of the PREFERRED biologics below:

<input type="checkbox"/> Humira®	<input type="checkbox"/> Cimzia®
<input type="checkbox"/> Simponi®	<input type="checkbox"/> Stelara®

OR

Moderate to Severe Chronic Plaque Psoriasis

Patient tried and failed at least one of either Phototherapy or Alternative System Therapy for at least three (3) months (check each tried below):

Phototherapy

OR

Alternative Systemic Therapy

UV Light Therapy Systemic Therapy

NB UV-B

PUVA

Oral Alternative

acitretin

methotrexate

cyclosporine

(continued on next page)

AND

- Trial and failure of two (2) of the **PREFERRED biologics** below (*check each tried*):

<input type="checkbox"/> Humira®	<input type="checkbox"/> Stelara®
<input type="checkbox"/> Cosentyx®	<input type="checkbox"/> Tremfya™

Medication being provided by (check applicable box(es) below):

- Physician's office

OR

- Specialty Pharmacy:

For Optima Commercial Members:

- PropriumRx

For Optima Family Care Members:

- Sentara Norfolk General CM Pharmacy

****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 & Therapeutics Committee: 9/17/2009**

REVISED/UPDATED: 6/3/2011; 8/12/2011; 1/16/2014; 2/5/2014; 2/25/2014; 4/3/2014; 4/28/2014; 5/2/2014; 8/8/2014; 10/30/2014; 5/21/2015; 12/27/2015; 8/12/2016; 9/22/2016; 12/11/2016; 8/3/2017; 12/11/2017; 1/2/2018; **1/11/2018.**