OPTIMA HEALTH PLAN

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 1-844-723-2094**. 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**.

Infliximab Category (MEDICAL)

Drug Requested - selected applicable drug below:	
PREFERRED	
❑ **Renflexis®** (infliximab-abda) **(Q5104)**	
Non-Preferred	
❑ **Inflectra®** (infliximab-dyyb) **(Q5103)**	❑ **Remicade®** (infliximab) **(J1745)**

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

Drug Name: _____ **Form/Strength:** _____

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

Diagnosis: _____ **ICD Code:** _____

Effective February 1, 2019, Renflexis® is the preferred infliximab product. Remicade® and Inflectra® are non-preferred.

Optima Health members are allowed to continue treatment with Remicade or Inflectra that was authorized prior to February 1st, 2019 until the end of their authorization period. At the time of renewal, patients will be required to switch to the preferred product, Renflexis®, unless contraindicated.

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 to ensure authorization will **NOT** be delayed.

Prescriber is a:

❑ **Rheumatologist**	❑ **Dermatologist**
❑ **Gastroenterologist**	❑ **Ophthalmologist**

Member diagnosed with one of the following (indicate which diagnosis):			
❑ **Rheumatoid Arthritis**	❑ **Ocular Sarcoidosis**	❑ **Ankylosing Spondylitis**	❑ **Plaque Psoriasis**
❑ **Psoriatic Arthritis**	❑ **Crohn's' Disease**	❑ **Ulcerative Colitis**	

❑ **Inflectra® OR Remicade® must have trial and failure of Renflexis®**

❑ Tried and failed **at least one DMARD** therapy for **at least three (3) months** for **ALL** diagnoses **except Plaque Psoriasis**:

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

(continued on next page)

❑ Member diagnosed with Plaque Psoriasis:

❑ Does member's Psoriasis involve: palms, soles, face, genitalia, or greater than 10% of total body surface area? ❑ Yes **OR** ❑ No

❑ Patient tried and failed **at least one** of either Phototherapy or Alternative Systemic therapy for **at least three (3) months (check each tried):**

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

❑ **UV Light Therapy** ❑ **Oral Alternative System Therapy**

❑ NB UV-B	❑ acitretin
❑ PUVA	❑ methotrexate
	❑ cyclosporine

❑ For Crohn's OR Ocular Sarcoidosis disease - 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)

Medication being provided by (check applicable box below):

❑ **Location/site of drug administration:** _____

NPI or DEA # of administering location: _____

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 & Therapeutic Committee:** 10/18/2018
REVISED/UPDATED: 12/30/2018