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; **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: **Olumiant®** (baricitinib)

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

Drug Form/Strength: ____________________

Dosing Schedule: ____________________ **Length of Therapy:** ____________________

Diagnosis: ____________________ **ICD Code:** ____________________

CLINICAL CRITERIA: To qualify, **ALL** appropriate boxes below **must** be checked or authorization will be delayed.

- **Prescriber is a Rheumatologist**

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

❑ Patient is at least 18 years old and diagnosed with one (1) of the following:

❑ **Moderate-to-severe Active Rheumatoid Arthritis**

AND

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

❑ methotrexate	❑ auranofin	❑ azathioprine
❑ hydroxychloroquine	❑ leflunomide	❑ sulfasalazine
❑ minocycline	❑ Other: ____________________	

AND

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

❑ Humira®	❑ Cimzia®	❑ Simponi®

AND

❑ Trial and failure of **BOTH** Kevzara and Xeljanz.

Medication being provided by Specialty Pharmacy - PropriumRx

(Signature page MUST be included with this request form.)

(Signature page must be attached to request form.)

*****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: ________________

Prescriber's DEA OR NPI #: ____

***Approved by Pharmacy and Therapeutics Committee**: 10/18/2018
REVISED/UPDATED: 12/30/2018