

# 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 1-844-723-2094. 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.

**Drug Requested:** Orencia® (abatacept) (J-0129) (**IV INFUSION ONLY**) (Medical)

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

Drug Form/Strength/Month: \_\_\_\_\_

Dosing Schedule: \_\_\_\_\_ Length of Therapy: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD Code: \_\_\_\_\_

**CLINICAL CRITERIA:** ALL boxes must be checked to qualify. If not checked, authorization process will be delayed.

The prescriber is a **Rheumatologist**

Patient has been diagnosed with one of the following moderate to severe (**check below**):

<input type="checkbox"/> rheumatoid arthritis	<input type="checkbox"/> psoriatic arthritis	<input type="checkbox"/> juvenile idiopathic arthritis
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Patient has tried and failed at least one previous DMARD therapy including, but not limited to: (**check each tried**)

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

### AND

Patient has tried and failed two (2) of the following biologics:

Cimzia™ IV                       Remicade®                       Simponi ARIA®

(Cimzia™, Remicade®, and Simponi ARIA® require Prior Authorization.  
Forms can be found at [www.Optimahealth.com](http://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: 2/16/2006

REVISED/UPDATED: 6/3/2011; 8/22/2011; 4/19/2012; 7/11/2012; 10/1/2012; 1/16/2014; 1/27/2014; 2/5/2014; 4/28/2014; 8/8/2014; 10/31/2014; 11/21/2014; 4/3/2015; 5/23/2015; 1/29/2016; 3/31/2016; 8/18/2016; 9/22/2016; 12/28/2016; 7/24/2017; 9/16/2017; 12/16/2017