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 or authorization 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 will be delayed.

- ❑ The prescriber is a **Rheumatologist**
- ❑ Patient has been diagnosed with **one** of the following moderate to severe **(check below):**

❑ **Rheumatoid Arthritis**	❑ **Psoriatic Arthritis**	❑ **Juvenile Idiopathic Arthritis**

AND

- ❑ Patient has tried and failed at least **one previous DMARD therapy** including, but not limited to: **(check each tried)**

❑ methotrexate	❑ sulfasalazine
❑ azathioprine	❑ leflunomide
❑ auranofin	❑ Other _____
❑ hydroxychloroquine	

AND

- ❑ **Patient has tried and failed two (2) of the following PREFERRED MEDICAL biologics:**

❑ **Cimzia™ IV**	❑ **Renflexis®**	❑ **Simponi® ARIA®**

(Cimzia™, Renflexis®, and Simponi® ARIA® require Prior Authorization. Forms can be found at www.Optimahealth.com)

(Continued on next page. Signature page must be attached with this request form.)

(Signature page must be included with request form)

Medication being provided by (check applicable box below):

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

  NPI or DEA # of administering location: _____

  OR

- ❑ **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; 6/4/2018;~~ **12/31/2018**