

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 moderate to severe rheumatoid arthritis
- Patient has tried and failed at least **one previous DMARD therapy** including, but not limited to: (**check each that have been 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:

- Cimzia™ Entyvio® Remicade®
- OR**
- Simponi® ARIA™

*(Cimzia™, Entyvio®, and Remicade® require Prior Authorization.
Forms can be found at 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