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):***

❑ rheumatoid arthritis	❑ psoriatic arthritis	❑ juvenile idiopathic arthritis

❑ 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 biologics:**

❑ Cimzia™ IV ❑ Remicade® ❑ Simponi ARIA®

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

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**