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: Orencia® SQ (abatacept) ***(Pharmacy)(Non-Preferred)***

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

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ ***ICD Code, if applicable:*** _____

CLINICAL CRITERIA: ALL boxes MUST be checked to qualify. Incomplete documentation will delay authorization process.

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

❑ rheumatoid arthritis	❑ psoriatic arthritis	❑ juvenile idiopathic arthritis

- ❑ Trial and failure of at least a ***90-day trial*** of at least ***one*** ***DMARD therapy*** including, but not limited to: ***(check all tried)***

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

AND

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

❑ Humira®	❑ Simponi®
❑ Cimzia®	❑ Stelara®

Forms can be found at www.Optimahealth.com.

Medication being provided by a Specialty Pharmacy (check applicable box below):

For Optima Commercial Members:
- ❑ **PropriumRx**

For Optima Family Care Members:
- ❑ **Sentara Norfolk General CM Pharmacy**

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: ~~10/28/2014~~; ~~5/22/2015~~; ~~12/29/2015~~; ~~3/30/3016~~; ~~5/6/2016~~; ~~6/23/2016~~; ~~8/11/2016~~; ~~9/22/2016~~; ~~12/21/2016~~; ~~8/4/2017~~; ~~12/28/2017~~; **1/11/2018**