

OPTIMA HEALTH PLAN

PHARMACY 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 and 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: **Rayos®** (prednisone delayed-release)

DRUG INFORMATION: Complete information below. Authorization process will be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

CLINICAL CRITERIA: ALL appropriate boxes must be checked to qualify or authorization process will be delayed. Chart notes documenting diagnosis and therapeutic failure MUST be attached to this request.

- Patient has a diagnosis of rheumatoid arthritis (submit chart notes documenting diagnosis)

AND
- Patient has tried and failed **30 days** of therapy with prednisone tablets (*submit chart notes documenting therapeutic failure*)

AND
- Patient has tried and failed **30 days** of therapy with dexamethasone (*submit chart notes documenting therapeutic failure*)

AND
- Patient has tried and failed **30 days** of therapy with methylprednisolone (*submit chart notes documenting therapeutic failure*)

****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: 10/16/2014
REVISED/UPDATED: 10/28/2014; 5/22/2015; 9/15/2016; 11/14/2016; 12/12/2016; 8/16/2017