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: **Remicade®** (Infliximab) **(J-1745)** ***(Medical) (Preferred)***

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

Drug Form/Strength/Month: _____

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

Diagnosis: _____ **ICD Code:** _____

*****Medical notes must be submitted to support each line checked on this request.*****

CLINICAL CRITERIA: ***Check applicable boxes below to qualify. Boxes must be checked or authorization process will be delayed.***

Prescriber is a: ❑ **Rheumatologist** ❑ **Dermatologist** ❑ **Gastroenterologist**

Member diagnosed with one of the following ***(indicate which diagnosis)***:

❑ **Rheumatoid Arthritis**	❑ **Ocular Sarcoidosis**	❑ **Ankylosing Spondylitis**	❑ **Plaque Psoriasis**
❑ **Psoriatic Arthritis**	❑ **Crohn's' Disease**	❑ **Ulcerative Colitis**	

❑ Tried and failed ***at least one DMARD*** therapy for ***at least three (3) months*** for ***ALL*** diagnoses ***except Plaque Psoriasis***:

❑ 6-mercaptopurine	❑ methotrexate	❑ azathioprine	❑ hydroxychloroquine
❑ auranofin	❑ sulfasalazine	❑ leflunomide	❑ aminosalicylates
❑ Other: _____			

Member diagnosed with Plaque Psoriasis:

❑ Does member's Psoriasis involve: palms, soles, face, genitalia, or greater than 10% of total body surface area? ❑ Yes **OR** ❑ No

❑ Patient tried and failed ***at least one*** of either Phototherapy or Alternative Systemic therapy for ***at least three (3) months*** ***(check each tried)*****:**

❑ **Phototherapy** **OR** ❑ **Alternative Systemic Therapy**:

❑ **UV Light Therapy** ❑ **Oral Alternative System Therapy**

❑ NB UV-B	❑ acitretin
❑ PUVA	❑ methotrexate
	❑ cyclosporine

For Crohn's OR Ocular Sarcoidosis disease - moderate to severe with inadequate response to:

❑ budesonide or high dose steroids (40-60 mg prednisone) **AND** ❑ DMARD/Immunosuppressive therapy

(continued on next page)

For Ulcerative Colitis indication - disease is moderately to severely active with inadequate response to:

- ❑ aminosalicylate (table above) **AND** ❑ high dose steroids (40-60 mg prednisone)

Medication being provided by (check applicable box below):

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

  NPI or DEA # of administering location: _____

  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 & Therapeutic Committee:**
REVISED/UPDATED ~~2/4/2010; 6/3/2011; 8/30/2011' 4/23/2012; 1/16/2014; 2/4/2014; 4/4/2014; 4/28/2014; 8/13/2014; 10/31/2014; 4/3/2015; 5/23/2015; 12/30/2015; 1/29/2016; 8/18/2016; 9/22/2016; 12/21/2016; 7/24/2017; 12/27/2017;~~ **4/30/2018**