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: **Rituxan®** (rituximab) **(J9310)** ***(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: Complete below ALL lines for appropriate diagnosis. Authorization process will be delayed if boxes for diagnosis are NOT checked.

RHEUMATOID ARTHRITIS (RA) INDICATION:

- ❑ Prescriber is a Rheumatologist

AND

- ❑ Patient has a diagnosis of moderate- to-severe rheumatoid arthritis

AND

- ❑ Patient has failed methotrexate therapy and all other forms of therapy.

AND

- ❑ Patient has tried and failed ***two (2):***
  - ❑ Humira® **OR** ❑ Enbrel™
  - **AND** ❑ Remicade®

AND

- ❑ Patient has tried and failed:
  - ❑ Xeljanz®/Xeljanz® XR

NON-HODGKIN's LYMPHOMA INDICATION:

- ❑ Prescriber is an Oncologist.

AND

- ❑ Patient has a diagnosis of B-cell non-Hodgkin's Lymphoma.

OR

- ❑ Patient has a diagnosis of CD20-positive Chronic Lymphocytic Leukemia

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GRANULOMATOSIS with POLYANGIITIS OR MICROSCOPIC POLYANGIITIS INDICATION, *INITIAL THERAPY*:

- ❑ Prescriber is a Rheumatologist or Nephrologist

AND

- ❑ Patient has a diagnosis of moderate- to-severe granulomatosis with polyangiitis

AND

- ❑ Patient will receive concurrent therapy with corticosteroids

AND

- ❑ Patient has failed cyclophosphamide therapy

OR

- ❑ Patient has a contraindication to cyclophosphamide therapy:

_____

GRANULOMATOSIS with POLYANGIITIS OR MICROSCOPIC POLYANGIITIS INDICATION, *MAINTENANCE THERAPY*:

- ❑ Prescriber is a Rheumatologist or Nephrologist

AND

- ❑ Induction occurred at least 4 months prior

AND

- ❑ Total duration of treatment does not exceed 24 months

AND

- ❑ Patient has failed methotrexate or azathioprine therapy

OR

- ❑ Patient has a contraindication to methotrexate or azathioprine therapy:

_____

(signature on next page)

***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 the Pharmacy and Therapeutic Committee**: 6/15/2006
REVISED/UPDATED: ~~7/17/2010~~; ~~6/3/2011~~; ~~9/7/2011~~; ~~4/24/2012~~; ~~10/1/2012~~; ~~8/13/2014~~; ~~10/31/2014~~; ~~4/3/2015~~; ~~5/23/2015~~; ~~12/30/2015~~; ~~1/29/2016~~; ~~3/30/2016~~; ~~9/22/2016~~; ~~12/11/2016~~; **7/27/2017**