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; 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: **Xeljanz®** (tofacitinib) **/ Xeljanz® XR®** (tofacitinib xr) ***(Non-Preferred)***

DRUG INFORMATION: 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 information will delay authorization process.

- ❑ Prescriber is a Rheumatologist
- ❑ Patient is at least 18 years old and diagnosed with one of the following:

❑ Moderate-to-Severe Active Rheumatoid Arthritis	❑ Active Psoriatic Arthritis

AND

- ❑ Patient has tried and failed ***at least one DMARD*** for at least ***three (3) months***: ***(Check each that have been tried)***

❑ methotrexate	❑ azathioprine	❑ hydroxychloroquine	❑ sulfasalazine
❑ leflunomide	❑ auranofin	❑ minocycline	❑ Other: _____

AND

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

❑ Cimzia®	❑ Humira®	❑ Simponi®

Forms can be found at www.optimahealth.com

Medication being provided by (check applicable box(es) below):

- ❑ **Physician's office**

OR

- ❑ **Specialty Pharmacy**:

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**: 4/17/2013
REVISED/UPDATED: ~~3/30/2016; 8/11/2016; 9/22/2016; 12/21/2016; 8/5/2017; 12/28/2017;~~ **2/19/2018**;