

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 moderate to severely active rheumatoid arthritis.
- Patient has tried and failed at least one DMARD for at least three (3) months: (Check each that have been tried)

<input type="checkbox"/> methotrexate	<input type="checkbox"/> azathioprine	<input type="checkbox"/> hydroxychloroquine	<input type="checkbox"/> sulfasalazine
<input type="checkbox"/> leflunomide	<input type="checkbox"/> auranofin	<input type="checkbox"/> minocycline	<input type="checkbox"/> Other: _____

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

<input type="checkbox"/> Cimzia®	<input type="checkbox"/> Humira®	<input type="checkbox"/> Simponi®
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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: 7/3/2013; 1/28/2014; 4/28/2014; 8/18/2014; 11/6/2014; 5/22/2015; 12/29/2015; 3/30/2016; 8/11/2016; 9/22/2016; 12/21/2016; 8/5/2017; 12/28/2017.