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 or authorization 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 to ensure authorization process will NOT be delayed..

- **Prescriber is (check applicable box below)**

❑ **Rheumatologist** ❑ **Gastroenterologist**

DIAGNOSIS: Applicable diagnosis below **MUST** be checked to qualify. All chart notes **MUST** be attached to this request to ensure authorization process will **NOT** be delayed.

Part A - DMARD therapy

❑ Trial and failure of at least **one DMARD** therapy for at least **three (3) months (check each tried)**:

❑ 6-mercaptopurine	❑ methotrexate	❑ azathioprine
❑ hydroxychloroquine	❑ auranofin	❑ sulfasalazine
❑ leflunomide	❑ aminosalicylates	❑ Other: _____
❑ olsalazine **(Crohn's/Ulcerative Colitis)**	❑ mesalamine **(Crohn's/Ulcerative Colitis)**	

❑ Moderate-to-Severe Active Rheumatoid Arthritis

❑ Prescriber is a Rheumatologist

AND

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

AND

❑ Patient has tried and failed at least **one DMARD** for at least **three (3) months (REFER TO PART A DMARD Therapy)**

AND

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

❑ Cimzia®	❑ Humira®	❑ Simponi®

❑ Active Psoriatic Arthritis

❑ Prescriber is a Rheumatologist

AND

- ❑ Patient has tried and failed at least **one DMARD** for at least **three (3) months** **(REFER TO PART A DMARD Therapy)**

AND

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

❑ **Cimzia®**	❑ **Humira®**	❑ **Stelara®**	❑ **Simponi®**

❑ For Ulcerative Colitis indication:

- ❑ Prescriber is a Gastroenterologist

AND

- ❑ Patient is at least 18 years old

AND

- ❑ Disease is moderately to severely active with inadequate response to:
  - ❑ 90 day trial of aminosalicylate or DMARD **(Refer to Part A)**, **AND**
  - ❑ budesonide or high dose steroids (40-60 mg prednisone daily)

AND

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

❑ **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 - 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 and Therapeutics Committee**: ~~4/17/2013~~; 7/19/2018;
REVISED/UPDATED: ~~3/30/2016~~; ~~8/11/2016~~; ~~9/22/2016~~; ~~12/21/2016~~; ~~8/5/2017~~; ~~12/28/2017~~; ~~2/19/2018~~; **11/23/2018**