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 1-844-668-1550**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization will be delayed**.

For Medicare Members: Medicare Coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. Additional indications may be covered at the discretion of the health plan.

Drug Requested: Rituxan® (rituximab) - **PV (J9310) (Medical) (Non-Preferred) (Pemphigus Vulgaris)**

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength/Month: _____

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

Diagnosis: _____ **ICD Code:** _____

- ❑ Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Member has a confirmed diagnosis of moderate- to-severe Pemphigus Vulgaris within the previous 24 months based on histological features of acantholysis via skin or mucosal biopsy and **one** of the following:
  - ❑ Tissue bound immunoglobulin G (IgG) antibodies against epithelial cell surface,

    OR

  - ❑ Serological detection of serum desmoglein-3 (DSg3) autoantibodies against epithelial cell surface either by indirect immunofluorescence microscopy or by enzyme-linked immunosorbent assay
- ❑ Presence of moderate-to-severely active disease, defined as overall PDAI activity score of greater than or equal to (>/=)15;

  AND

- ❑ Member has been receiving standard-of-care corticosteroids consisting of 60-120mg/day oral prednisone or equivalent for at least 60 days (within the past 90 days)

(Continued on next page; signature page is required to process request.)

(Please ensure signature page is attached to form.)

Medication being provided by (check box below that applies):

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

  NPI or DEA # of administering location: _____

  OR

- ❑ **Specialty Pharmacy: PropriumRx**

For urgent reviews: Practitioner should call Optima Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Optima's definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

*****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.****

Member 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: 9/29/2018; **(Reformatted)** 3/19/2019; 7/8/2019; **9/24/2019**.