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. **If the information provided is not complete, correct, or legible, the authorization process may be delayed.**

Drug Requested: Enbrel® (etanercept)

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

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

Diagnosis: _____ **ICD Code, if applicable:** _____

Member's Weight: _____ **kg**

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.

PART A – DMARD Therapy - Trial and failure of **at least one DMARD** for at least **three (3) months (check each tried)**:

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

DIAGNOSIS: Check below the diagnosis that applies. **Dosing: SubQ:** 50 mg once weekly

❑ **Rheumatoid Arthritis**	❑ **Polyarticular Juvenile Idiopathic Arthritis** (≥ 2 years of age)	❑ **Psoriatic Arthritis**

- ❑ Member has **ONE** of the diagnoses above **(check diagnosis above that applies)**
- ❑ Prescriber is or consultation with a **Rheumatologist**
- ❑ Member tried and failed at least **one DMARD** therapy for at least **three (3) months (REFER TO PART A above and check each DMARD therapy tried)**

❑ **DIAGNOSIS: Ankylosing Spondylitis (AS)**
Dosing: SubQ: 50 mg once weekly

- ❑ Member has a diagnosis of **ankylosing spondylitis**
- ❑ Prescribed by or in consultation with a **Rheumatologist**
- ❑ Member tried and failed, has a contraindication, or intolerance to **TWO** NSAIDs

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❑ **DIAGNOSIS: Moderate-to-Severe Plaque Psoriasis**
Dosing: SubQ: Initial: 50 mg twice weekly for 3 months. **Maintenance:** 50 mg once weekly

- ❑ Member is ≥ 4 years of age and has a diagnosis of moderate-to-severe **plaque psoriasis**
- ❑ Prescribed by or in consultation with a **Dermatologist**
- ❑ Member tried and failed at least **one** of either Phototherapy or Alternative Systemic Therapy for at least **three (3) months** **(check each tried below)**:

❑ **Phototherapy:**	❑ **Alternative Systemic Therapy:**
❑ **UV Light Therapy**	❑ **Oral Medications**
❑ NB UV-B	❑ acitretin
❑ PUVA	❑ methotrexate
	❑ cyclosporine

Medication being provided by a 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.*

Member Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***Approved by Pharmacy & Therapeutics Committee:** 9/17/2009
REVISED/UPDATED: ~~6/3/2011; 8/12/2011; 1/16/2014; 2/5/2014; 2/25/2014; 4/3/2014; 4/28/2014; 5/2/2014; 8/8/2014; 10/30/2014; 5/21/2015; 12/27/2015; 8/12/2016; 9/22/2016; 12/11/2016; 8/3/2017; 12/11/2017; 1/2/2018; 1/11/2018; 11/24/2018; 9/28/2019; 11/26/2019; 2/4/2022;~~
12/20/2022.