OPTIMA FAMILY CARE MEDALLION 4.0

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 1-844-723-2094. 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: **Cimzia™** (certolizumab) **IV (J-0717)** ***(Medical)***

(Medical: SQ Lyophilized powder for reconstitution)

***DRUG INFORMATION:* Complete all information below or authorization process will be delayed.**

Drug Form/Strength/Quantity: _____

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

Diagnosis: _____ **ICD Code:** _____

CLINICAL CRITERIA*: *ALL appropriate lines must be checked to ensure authorization will NOT be delayed.

Prescriber is a**:** ❑ **Gastroenterologist** **OR** ❑ **Rheumatologist**

❑ **Crohn's Disease**

❑ Failure of budesonide or high dose (40-60mg prednisone) steroids

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

- ❑ methotrexate
- ❑ azathioprine
- ❑ auranofin
- ❑ hydroxhlorquine
- ❑ sulfasalazine
- ❑ leflunomide
- ❑ Other

❑ **Rheumatoid Arthritis** ❑ **Psoriatic Arthritis,**

❑ **Ankylosing Spondylitis**

❑ Patient has tried and failed ***at least one (1)* DMARD for at least three (3) months**: ***(Check each that has been tried)***

- ❑ methotrexate
- ❑ azathioprine
- ❑ auranofin
- ❑ hydroxhlorquine
- ❑ sulfasalazine
- ❑ leflunomide
- ❑ Other

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

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

NPI or DEA # of administering location: _____

OR

❑ **Specialty Pharmacy**: ❑ **PropriumRx** **OR** ❑ **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 #: _____

REVISED/UPDATED: 7/1/2018