

# OPTIMA FAMILY CARE MEDALLION 4.0

## 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:** Cimzia™ SQ (certolizumab) (Pharmacy: Prefilled syringe) (*Preferred*)

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

Drug Form/Strength: \_\_\_\_\_

Dosing Schedule: \_\_\_\_\_ Length of Therapy: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD Code, if applicable: \_\_\_\_\_

- Cimzia™ is available under **both** Medical and Pharmacy benefits.

**CLINICAL CRITERIA:** ALL boxes MUST be checked to ensure authorization will NOT be delayed.

Prescriber is:  Gastroenterologist **OR**  Rheumatologist

**DIAGNOSIS:** Check the applicable diagnosis below to ensure authorization will NOT be delayed.

Crohn's Disease

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

**AND**

- Patient tried and failed at least one maintenance therapy for at least three (3) months (*check each tried*):

<input type="checkbox"/> methotrexate	<input type="checkbox"/> sulfasalazine	<input type="checkbox"/> azathioprine	<input type="checkbox"/> leflunomide
<input type="checkbox"/> olsalazine	<input type="checkbox"/> 6-mercaptopurine	<input type="checkbox"/> mesalamine	<input type="checkbox"/> cyclosporine

Rheumatoid Arthritis

Psoriatic Arthritis

Ankylosing Spondylitis

- Patient tried and failed at least one DMARD for at least three (3) months (*check each tried*):

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

(signature on next page)

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

Physician's office

**OR**

Specialty Pharmacy - 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