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: **Simponi® ARIA™** (golimumab) **(J-1602)** ***(Medical)***

DRUG INFORMATION: Complete information below. If incomplete, authorization process will be delayed.

Drug Form/Strength: ______________________________

Dosing Schedule: ______________________ **Length of Therapy:** ______________

Diagnosis: ______________________ **ICD Code:** ______________

SIMPONI® ARIA™ DOSE______________ **FREQUENCY**______________

CLINICAL CRITERIA: To qualify, ALL appropriate boxes below must be checked or authorization process will be delayed.

Prescriber is a: ❑ **Rheumatologist**

DIAGNOSIS: Applicable diagnosis below MUST be checked to qualify. All chart notes MUST be attached to this request or authorization process will be delayed.

Part A - DMARD therapy

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

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

❑ **Moderate-to-severe Active Rheumatoid Arthritis**	❑ **Active Ankylosing Spondylitis**	❑ **Active Psoriatic Arthritis**

❑ Trial and failure of ***at least one DMARD*** therapy for ***at least three (3) months*** ***(check each tried)*** ***(Refer to Part A).***

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

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

NPI or DEA # of administering location: ______________________________

OR

❑ **Specialty Pharmacy:** ❑ **PropriumRx** ❑ **Sentara Norfolk General CM Pharmacy**

(signature on next page)

*****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: ________________

Prescriber's DEA OR NPI #: ____

REVISED/UPDATED: 7/1/2018