OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

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 1-844-348-3720**. 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 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 qualify 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
- ❑ hydroxychloroquine
- ❑ 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
- ❑ hydroxychloroquine
- ❑ 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** ❑ **Sentara Norfolk General CM Pharmacy**

(continued on next page; signature MUST be included with this request)

(Signature page; MUST be included with this request)

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: ~~8/1//2017; 4/30/2018; 8/17/2018;~~ **10/8/2018**