OPTIMA HEALTH COMMUNITY 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: ❑ **Gastroenterologist** ❑ **Rheumatologist** ❑ **Dermatologist**

PART A – DMARD Therapy

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

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

❑ Crohn's Disease

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

AND

❑ Patient has tried and failed at least **one DMARD** for at least **three (3) months**: **(REFER TO PART A for list of DMARD therapy drugs; check each tried)**

AND

❑ Trial and failure of **Humira®**

❑ Rheumatoid Arthritis	❑ Psoriatic Arthritis	❑ Ankylosing Spondylitis

❑ Patient has tried and failed **at least ONE (1) DMARD** for at least **three (3) months: (REFER TO PART A for list of DMARD therapy drugs; check each tried)**

(continued on next page)

AND

- ❑ Trial and failure of the following **TWO (2)** biologics:
  - ❑ **Enbrel®** **AND** ❑ **Humira®**

❑ Moderate-to-Severe Chronic Plaque Psoriasis

- ❑ Patient tried and failed **at least one** of either Phototherapy or Alternative System Therapy for at least **three (3) months** **(check each tried below)**:
  - ❑ **Phototherapy** **OR** ❑ **Alternative Systemic Therapy**:
    - ❑ **UV Light Therapy**
    - ❑ **Oral Alternative System Therapy**

❑ NB UV-B	❑ acitretin
❑ PUVA	❑ methotrexate
	❑ cyclosporine

AND

- ❑ Trial and failure of the following **TWO (2)** **PREFERRED** biologics:

❑ **Enbrel®**	❑ **Humira®**	❑ **methotrexate**

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 #: _____

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