OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

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)**

DRUG INFORMATION: Complete information below or authorization 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 qualify or authorization will be delayed.

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

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

❑ **Crohn's Disease – moderate to severe active**

- ❑ Trial and failure of a compliant regimen of oral corticosteroids (moderate to severe CD) unless contraindicated or intravenous corticosteroids (severe and fulminant CD or failure to respond to oral corticosteroids),

AND

- ❑ Trial and failure of a compliant regimen of **azathioprine or mercaptopurine** for **three (3) consecutive months (check applicable drug)**: ❑ azathioprine ❑ mercaptopurine

AND

- ❑ Trial and failure of a compliant regimen of parental **methotrexate** for **three (3) consecutive months**

AND

- ❑ Patient tried and failed **Humira®**

❑ **Rheumatoid Arthritis – moderate to severe**

- ❑ Trial and failure of, contraindication, or adverse reaction to methotrexate,

AND

(continued on next page)

❑ Rheumatoid Arthritis – moderate to severe

❑ Trial and failure of **at least ONE (1) other DMARD (check each tried)**:

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

AND

❑ Patient has tried and failed Humira® or Enbrel®

❑ Psoriatic Arthritis

❑ Trial and failure of methotrexate; **OR**

❑ Requested medication will be used in conjunction with methotrexate; **OR**

❑ Patient has a contraindication to methotrexate (e.g., alcohol abuse, cirrhosis, chronic liver disease, or other contraindication);

AND

❑ Trial and failure of Humira® or Enbrel®

❑ Ankylosing Spondylitis

❑ Trial and failure of an adequate trial of at least **two (2) NSAIDS**; **OR**

❑ Use of NSAIDs is contraindicated in patient

AND

❑ Trial and failure of the following:

❑ **Humira®**	**OR**	❑ **Enbrel®**

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: ~~4/6/2018; 10/28/2018; 11/18/2018;~~ **12/13/2018**