

**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: **Entyvio® IV (vedolizumab) (J3380) (Medical)**

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

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

CLINICAL CRITERIA: Check boxes below. All applicable boxes **MUST** be checked to qualify to ensure authorization will **NOT** be delayed.

- Prescriber is a: Gastroenterologist
- Diagnosis of: Crohn's Disease OR Ulcerative Colitis:
- Patient has tried and failed **at least one previous 5-Aminosalicylates or Immunomodulators therapy (check below that applies)**

<input type="checkbox"/> methotrexate	<input type="checkbox"/> azathioprine	<input type="checkbox"/> auranofin
<input type="checkbox"/> sulfasalazine	<input type="checkbox"/> oral aminosalicylates	<input type="checkbox"/> leflunomide
<input type="checkbox"/> 6-mercaptopurine	<input type="checkbox"/> Apriso®	<input type="checkbox"/> Lialda™
<input type="checkbox"/> Pentasa®		

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

(continued on next page; signature **MUST** be attached to this request.)

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*****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: 8/1/2017; 8/26/2017; 12/27/2017; 4/30/2018; 8/18/2018; 10/8/2018; 11/18/2018;**