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® (vedolizumab) **(J3380)**

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: ❑ **Rheumatologist** ❑ **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)**

❑ methotrexate	❑ azathioprine	❑ auranofin
❑ balsalazide	❑ sulfasalazine	❑ leflunomide
❑ mesalamine_____	❑ olsalazine	❑ oral aminosalicylates
❑ 6-mercaptopurine		

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**