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: **Simponi® ARIA™** (golimumab) **(J-1602) (Medical)**

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

Drug Form/Strength: _____

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

Diagnosis: _____ **ICD Code:** _____

SIMPONI® ARIA™ DOSE: _____ **FREQUENCY:** _____

CLINICAL CRITERIA: To qualify, **ALL** appropriate boxes below **must** be checked to ensure authorization will **NOT** be delayed**.**

Prescriber is a: ❑ **Rheumatologist**

DIAGNOSIS: Applicable diagnosis below **MUST** be checked to qualify. All chart notes **MUST** be attached to this request to ensure authorization will **NOT** be delayed.

Part A - DMARD therapy

❑ Trial and failure of **at least one DMARD** therapy for **at least three (3) months (check each tried)**:

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

❑ **Moderate-to-severe Active Rheumatoid Arthritis**	❑ **Active Ankylosing Spondylitis**	❑ **Active Psoriatic Arthritis**

❑ Trial and failure of **at least one DMARD** therapy for **at least three (3) months (check each tried) (Refer to Part A).**

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

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Medication being provided by (check applicable box(es) 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: _____

Prescriber's DEA OR NPI #: _____

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