

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: **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 **(check each tried):**

<input type="checkbox"/> methotrexate	<input type="checkbox"/> auranofin	<input type="checkbox"/> azathioprine
<input type="checkbox"/> hydroxychloroquine	<input type="checkbox"/> leflunomide	<input type="checkbox"/> sulfasalazine
<input type="checkbox"/> Other: _____		

<input type="checkbox"/> Moderate-to-severe Active Rheumatoid Arthritis	<input type="checkbox"/> Active Ankylosing Spondylitis	<input type="checkbox"/> Active Psoriatic Arthritis
--	---	--

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

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

(Signature page **MUST** be included with this request.)

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 #: _____

REVISED/UPDATED: 8/1/2017; 8/31/2017; 1/8/2018; 4/30/2018; 8/30/2018; 10/8/2018; 11/18/2018; (REFORMATTED) 2/5/19.