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: Simponi® (golimumab) **SQ ONLY (PHARMACY)**

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

Drug Form/Strength: _____

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

Diagnosis: _____ **ICD Code, if applicable:** _____

CLINICAL CRITERIA: ALL boxes **MUST** be checked to qualify. Incomplete documentation will delay authorization process.

Prescriber is: ❑ **Rheumatologist** ❑ **Gastroenterologist** ❑ **Dermatologist**

DIAGNOSIS: Check one of the diagnoses below to qualify. If NOT checked, authorization will be delayed.

❑ **Rheumatoid Arthritis**	❑ **Psoriatic Arthritis**

❑ Trial and failure of, contraindication, or adverse reaction to methotrexate alone (must be in combination with methotrexate); **AND**

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

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

AND

❑ Trial and failure of Humira® OR Enbrel®

DIAGNOSIS: Ankylosing Spondylitis. Complete ALL criteria below that applies or authorization will be delayed.

❑ Trial and failure of an adequate trial of at least 2 NSAIDs; **OR**
❑ Use of NSAIDs is contraindicated.

(continued on next page)

DIAGNOSIS: Moderate to severe active Ulcerative Colitis. Complete ALL criteria below that applies or authorization will be delayed.

- ❑ Trial and failure of a complaint regimen of oral or rectal aminosalicylates (i.e., sulfasalazine or mesalamine) for **two (2)** consecutive months, **AND**
- ❑ Trail and failure of a compliant regimen of oral corticosteroids (for moderate to severe CD) unless contraindicated, or intravenous corticosteroids (for 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.

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

❑ **Physician's office** **OR** ❑ **Specialty Pharmacy - PropriumRx**

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 #: _____

***Approved by Pharmacy and Therapeutics Committee**: 6/21/2010
REVISED/UPDATED: ~~4/12/2011; 8/22/2011; 7/9/2012; 7/22/2013, 9/19/2013; 11/20/2013; 1/27/2014; 2/4/2014; 4/4/2014; 4/28/2014; 8/18/2014; 11/5/2014; 5/22/2015~~**,** ~~12/15/15; 12/23/2015; 3/30/2016~~; ~~9/22/2016~~; ~~12/11/2016; 8/5/2017;12/282017; 11/23/2018;~~ **12/13/2018**