# OPTIMA HEALTH COMMUNITY CARE

## 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:** **Cimzia™** (certolizumab) **(J-0717)** ***(Medical)***

***(Medical: SQ Lyophilized powder for reconstitution)***

***DRUG INFORMATION: Complete information below. Authorization process will be delayed if incomplete.***

**Drug Form/Strength/Quantity:** _____

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

**Diagnosis:** _____ **ICD Code:** _____

***CLINICAL CRITERIA: ALL appropriate lines must be checked to qualify or authorization process will be delayed.***

Prescriber is a**:** ❑ **Gastroenterologist** **OR** ❑ **Rheumatologist**

❑ **Crohn's Disease**

❑ Failure of budesonide or high dose (40-60mg prednisone) steroids

❑ Patient has tried and failed **at least one DMARD for at least three (3) months**: ***(Check each that has been tried)***

- ❑ methotrexate
- ❑ azathioprine
- ❑ auranofin
- ❑ hydroxhlorquine
- ❑ sulfasalazine
- ❑ leflunomide
- ❑ Other

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

❑ **Ankylosing Spondylitis**

❑ Patient has tried and failed ***at least one (1)*** **DMARD for at least three (3) months**: ***(Check each that has been tried)***

- ❑ methotrexate
- ❑ azathioprine
- ❑ auranofin
- ❑ hydroxhlorquine
- ❑ sulfasalazine
- ❑ leflunomide
- ❑ Other

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

❑ **Location/site of drug administration:** _____

**NPI or DEA # of administering location:** _____

**OR**

❑ **Specialty Pharmacy**: ❑ **PropriumRx** ❑ **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: _____

**DEA OR NPI #:** _____

**REVISED/UPDATED:** ~~8/1//2017;~~ **4/30/2018**