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:** _____

Cimzia™ is available under both the medical and pharmacy benefits.

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):

❑ **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 #: _____

REVISED/UPDATED: 8/1//2017