OPTIMA HEALTH COMMUNITY CARE

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 1-800-319-5003. 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™ SQ** (certolizumab) (***Pharmacy: Prefilled syringe***) ***(Preferred)***

DRUG INFORMATION: Complete information below. If incomplete, authorization process will be delayed.

Drug Form/Strength: ____

Dosing Schedule: ______________________________ **Length of Therapy:** ____________________

Diagnosis: ______________________________ ***ICD Code, if applicable:*** ________________

- ***Cimzia™ is available under both Medical and Pharmacy benefits.***

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

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

DIAGNOSIS: Check the applicable box below. If not checked, authorization process will be delayed.

❑ **Crohn's Disease**

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

AND

❑ Patient tried and failed ***at least one maintenance therapy*** **for at** ***least three (3) months*** ***(check each tried)***:

❑ methotrexate	❑ sulfasalazine	❑ azathioprine	❑ leflunomide
❑ olsalazine	❑ 6-mercaptopurine	❑ mesalamine	❑ cyclosporine

❑ **Rheumatoid Arthritis** ❑ **Psoriatic Arthritis** ❑ **Ankylosing Spondylitis**

❑ Patient tried and failed ***at least one DMARD*** **for at least three (3) months** ***(check each tried)***:

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

(signature on next page)

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

- ❑ **Physician's office**

  OR

- ❑ **Specialty Pharmacy:** ❑ **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: 4/6/2018