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: **Simponi® ARIA™** (golimumab) **(J-1602)**

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

Drug Form/Strength: _____

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

Diagnosis: _____ **ICD Code:** _____

SIMPONI® ARIA™ DOSE_____ **FREQUENCY**_____

Medication is provided by the physician's office.

CLINICAL CRITERIA: To qualify, ALL appropriate boxes below must be checked or authorization process will be delayed.

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

- ❑ For a diagnosis of **rheumatoid arthritis**:
  - ❑ Patient has tried and failed at least ***one previous DMARD therapy*** below:
    - ❑ methotrexate ❑ azathioprine ❑ auranofin ❑ hydroxychloroquine
    - ❑ sulfasalazine ❑ leflunomide ❑ Other: _____

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;~~ **8/31/2017**;