

OPTIMA HEALTH PLAN

PHARMACY PRIOR AUTHORIZATION 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 1-844-202-5034. 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: SQ Lyophilized powder for reconstitution)

DRUG INFORMATION: Complete all 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 to ensure authorization process will **NOT** be delayed.

Prescriber is: 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 tried):**
 - Methotrexate sulfasalazine
 - azathioprine leflunomide
 - auranofin Other: _____
 - hydroxchlorquine

Rheumatoid Arthritis **Psoriatic Arthritis**

Ankylosing Spondylitis

- Patient has tried and failed **at least one (1) DMARD for at least three (3) months (check each tried):**
 - Methotrexate sulfasalazine
 - azathioprine leflunomide
 - auranofin Other: _____
 - hydroxchlorquine

Medication being provided by (check applicable box below):

Location/site of drug administration: _____
NPI or DEA # of administering location: _____

OR

Specialty Pharmacy – Briova SpecialtyRx

****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 & Therapeutics Committee: 9/17/2009;

REVISED/UPDATED: 6/3/2011; 8/12/2011; 11/29/2011; 7/9/12; 8/1/2013; 1/16/2014; 2/7/2014; 4/28/2014; 8/8/2014; 10/31/2014; 2/6/2015; 4/3/2015; 5/23/2015; 1/29/2016; 3/31/2016; 8/17/2016; 9/22/2016; 12/28/2016; 2/8/2017; 7/24/2017; 7/10/2018