OPTIMA HEALTH PLAN

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 1-844-202-5034. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct.***

Drug Requested: **Cimzia™** (certolizumab) **(J-0717)**

(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 boxes 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**: (C***heck 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**: ❑ **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; 9/12/2017;~~ **10/4/2017**;