OPTIMA HEALTH PLAN

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 1-800-750-9692. 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**® (golimumab)

DRUG INFORMATON: Complete information below. If incomplete, 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. Incomplete documentation will delay authorization process.

- **Prescriber is** (***check applicable box below***)

❑ **Rheumatologist** ❑ **Gastroenterologist** ❑ **Dermatologist**

❑ Patient has ***one*** of the following diagnoses ***(check applicable diagnosis below):***

❑ Rheumatoid Arthritis	❑ Active Psoriatic Arthritis	❑ Ankylosing Spondylitis

❑ Patient has tried and failed **at least** ***one previous DMARD*** **therapy** below

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

AND

❑ **Patient has tried and failed both**

❑ Enbrel® (etanercept) **AND** ❑ Humira® (adalimumab)

AND

❑ Xeljanz®/Xeljanz® XR (tofacitinib citrate) ***(only for Rheumatoid Arthritis diagnosis)***

❑ **Diagnosis of**: moderate-severe, active **Ulcerative Colitis** in a patient who is chronically steroid dependent:

❑ The patient has had an inadequate response or failure to tolerate either:

❑ oral aminosalicylates **OR**	❑ azathioprine **OR**	❑ 6-mercaptopurine

AND

❑ **Patient has tried and failed both**

❑ Remicade® (infliximab) **AND** ❑ Humira® (adalimumab)

❑ **SIMPONI™ DOSE**____________________ **FREQUENCY**______________________________

(Enbrel®, Humira® and Remicade® require a Prior Authorization. Forms can be found at www.Optimahealth.com)

(signature on next page)

***Medication being provided by** (**check applicable box(es) 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 and Therapeutics Committee**: 6/21/2010
REVISED/UPDATED: ~~4/12/2011; 8/22/2011; 7/9/2012; 7/22/2013, 9/19/2013; 11/20/2013; 1/27/2014; 2/4/2014; 4/4/2014; 4/28/2014; 8/18/2014; 11/5/2014; 5/22/2015~~, ~~12/15/15; 12/23/2015; 3/30/2016~~; ~~9/22/2016~~; ~~11/29/2016~~; ~~12/13/2016; 9/17/2017;~~ **10/7/2017**;