

# 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 1-844-723-2094. 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 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 or authorization process will 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

**For Optima Commercial Members:**  PropriumRx

**For Optima Family Care Members:**  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 #: \_\_\_\_\_

\*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; 4/30/2018