

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 1-844-723-2094. 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. 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:	<input type="checkbox"/> Gastroenterologist	OR	<input type="checkbox"/> Rheumatologist	
<input type="checkbox"/> <u>Crohn's Disease</u>			<input type="checkbox"/> <u>Rheumatoid Arthritis</u> <input type="checkbox"/> <u>Psoriatic Arthritis,</u>	
<input type="checkbox"/> Failure of budesonide or high dose (40-60mg prednisone) steroids			<input type="checkbox"/> <u>Ankylosing Spondylitis</u>	
<input type="checkbox"/> Patient has tried and failed <u>at least one DMARD for at least three (3) months:</u> <i>(Check each that has been tried)</i>			<input type="checkbox"/> Patient has tried and failed <u>at least one (1) DMARD for at least three (3) months:</u> <i>(Check each that has been tried)</i>	
<input type="checkbox"/> methotrexate	<input type="checkbox"/> sulfasalazine		<input type="checkbox"/> methotrexate	<input type="checkbox"/> sulfasalazine
<input type="checkbox"/> azathioprine	<input type="checkbox"/> leflunomide		<input type="checkbox"/> azathioprine	<input type="checkbox"/> leflunomide
<input type="checkbox"/> auranofin	<input type="checkbox"/> Other: _____		<input type="checkbox"/> auranofin	<input type="checkbox"/> Other: _____
<input type="checkbox"/> hydroxhlorquine			<input type="checkbox"/> hydroxhlorquine	

Medication being provided by (check applicable box below):

Physician's office

OR

Specialty Pharmacy:

PropriumRx

*****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; 8/4/2016; 9/22/2016; 12/28/2016; 2/8/2017; 7/24/2017.