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
  - ❑ 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** ***(check each tried)*****:**
  - ❑ Methotrexate
  - ❑ azathioprine
  - ❑ auranofin
  - ❑ hydroxhlorquine
  - ❑ sulfasalazine
  - ❑ leflunomide
  - ❑ Other: _____

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**