OPTIMA HEALTH PLAN

MEDICAL/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™ IV (certolizumab) **(J-0717)**
(Medical: SQ Lyophilized powder for reconstitution)

DRUG INFORMATION: Complete information below or authorization will be delayed.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **kg** **Date within last 30 days**: _____

CLINICAL CRITERIA: **ALL** boxes **MUST** be checked to qualify to ensure authorization will **NOT** be delayed.

Prescriber is: ❑ **Gastroenterologist** **OR** ❑ **Rheumatologist**

PART A - DMARD therapy - Trial and failure of at least **ONE (1) DMARD** therapy for at least **THREE (3) months** **(check each tried):**

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

DIAGNOSIS: Crohn's Disease – boxes **must** be checked to qualify for approval of drug requested.

❑ Failure of budesonide or high dose (40-60mg prednisone) steroids

AND

❑ Patient has tried and failed at least **one DMARD for at least three (3) months** **(REFER TO PART A above and check each DMARD therapy tried)**

DIAGNOSIS: Check applicable diagnosis below.

❑ **Rheumatoid Arthritis**	❑ **Psoriatic Arthritis**	❑ **Ankylosing Spondylitis**

❑ Patient has tried and failed at least **one (1) DMARD** for at least **three (3) months** **(REFER TO PART A above and check each DMARD therapy tried).**

(continued on next page)

Medication being provided by (check applicable box below):

- ❑ **Location/site of drug administration:** _____

  NPI or DEA # of administering location: _____

  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; 8/17/2016; 9/22/2016; 12/28/2016; 2/8/2017; 7/24/2017; 4/30/2018;~~ **11/20/2018**