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: Cimzia™ SQ (certolizumab) **(Pharmacy: Prefilled syringe) (Preferred)**

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

Drug Form/Strength: _____

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

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

- Cimzia™ is available under **both** Medical and Pharmacy benefits**.**

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

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

DIAGNOSIS: Check the applicable box below to ensure authorization will **NOT** be delayed.

❑ Crohn's Disease

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

AND

❑ Patient tried and failed **at least one maintenance therapy for at least three (3) months (check each tried)**:

❑ methotrexate	❑ sulfasalazine	❑ azathioprine	❑ leflunomide
❑ olsalazine	❑ 6-mercaptopurine	❑ mesalamine	❑ cyclosporine

❑ Rheumatoid Arthritis ❑ Psoriatic Arthritis ❑ Ankylosing Spondylitis

❑ Patient tried and failed **at least one DMARD for at least three (3) months (check each tried)**:

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

(continued on next page)

❑ Moderate to Severe Chronic Plaque Psoriasis

❑ Patient tried and failed **at least one** of either Phototherapy or Alternative System Therapy for **at least three (3) months (check each tried below)**:

❑ **Phototherapy** **OR** ❑ **Alternative Systemic Therapy**:

❑ **UV Light Therapy** ❑ **Oral Alternative System Therapy**

❑ NB UV-B	❑ acitretin
❑ PUVA	❑ methotrexate
	❑ cyclosporine

Medication being provided by (check applicable box below):

❑ **Physician's office**

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: ~~10/28/2014; 5/21/2015; 12/27/2015; 4/11/2016; 8/8/2016; 9/22/2016; 12/11/2016; 8/3/2017; 12/30/2017;~~ **9/26/2018**