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. If incomplete, authorization process 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. Incomplete information will delay authorization process.

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

DIAGNOSIS: Check the applicable box below. If not checked, authorization process will 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: _____	

(signature on next page)

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**