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) **(J-0717)** ***(Pharmacy: Prefilled syringe)***

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 a**:** ❑ **Gastroenterologist** **OR** ❑ **Rheumatologist**

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❑ **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 that has been tried)***
  - ❑ methotrexate ❑ sulfasalazine
  - ❑ azathioprine ❑ leflunomide
  - ❑ auranofin ❑ Other: _____
  - ❑ hydroxhlorquine
- ❑ Patient has tried and **both** of the following TNFs:
  - ❑ Humira® **AND** ❑ Remicade®

OR

  - ❑ Simponi® Aria™

❑ **Rheumatoid Arthritis** ❑ **Psoriatic Arthritis**

❑ **Ankylosing Spondylitis**

- ❑ Patient has tried and failed **at least one DMARD for at least three (3) months**: ***(Check each that has been tried)***
  - ❑ methotrexate ❑ sulfasalazine
  - ❑ azathioprine ❑ leflunomide
  - ❑ auranofin ❑ Other: _____
  - ❑ hydroxhlorquine
- ❑ Patient has tried and **both** of the following TNFs:
  - ❑ Humira® **AND** ❑ Enbrel™

AND

- ❑ Patient has tried and failed: ❑Xeljanz® / Xeljanz® XR ***(Rheumatoid Arthritis diagnosis only)***

(Enbrel™, Remicade® and Humira® require Prior Authorization. Form can be found at www.Optimahealth.com)

(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**;