

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.*

Drug Requested: **Simponi®** (golimumab)

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. Incomplete documentation will delay authorization process.

Prescriber is a: Rheumatologist Gastroenterologist Dermatologist

Diagnosis of: rheumatoid arthritis, psoriatic arthritis or ankylosing spondylitis:

Patient has tried and failed at least one previous DMARD therapy, AND

<input type="checkbox"/> methotrexate	<input type="checkbox"/> azathioprine	<input type="checkbox"/> auranofin
<input type="checkbox"/> hydroxychloroquine	<input type="checkbox"/> sulfasalazine	
<input type="checkbox"/> leflunomide	<input type="checkbox"/> Other: _____	

Patient has tried and failed both

Enbrel® (etanercept) AND Humira® (adalimumab)

AND

Xeljanz®/Xeljanz® XR (tofacitinib citrate) (*only for Rheumatoid Arthritis diagnosis*)

Diagnosis of: moderate-severe, active ulcerative colitis in a patient who is chronically steroid dependent:

The patient has had an inadequate response or failure to tolerate either:

oral aminosalicylates azathioprine OR 6-mercaptopurine,

AND

The patient has tried and failed both

Remicade® (infliximab) AND Humira® (adalimumab)

SIMPONI™ DOSE _____ **FREQUENCY** _____

(Enbrel® and Humira® both require Prior Authorization.

Forms can be found at www.Optimahealth.com)

(signature on next page)

Medication being provided by (check applicable box(es) 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 and Therapeutics Committee: 6/21/2010

REVISED/UPDATED: 4/12/2011; 8/22/2011; 7/9/2012; 7/22/2013; 9/19/2013; 11/20/2013; 1/27/2014; 2/4/2014; 4/4/2014; 4/28/2014; 8/18/2014; 11/5/2014; 5/22/2015; 12/15/15; 12/23/2015; 3/30/2016; 9/22/2016; 12/11/2016; 8/5/2017.