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: **Simponi®** (golimumab) **SQ ONLY** ***(Preferred)***

DRUG INFORMATON: ***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: ❑ **Rheumatologist** ❑ **Gastroenterologist** ❑ **Dermatologist**

DIAGNOSIS: ***Check one of the diagnoses below to qualify .If NOT checked, authorization process will be delayed.***

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

❑ Trial and failure of **at least** ***one previous DMARD*** therapy for ***at least three (3) months*** ***(check each tried):***

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

DIAGNOSIS: Moderate-severe, active Ulcerative Colitis in a patient who is chronically steroid dependent. Complete ALL that apply below or authorization process will be delayed.

❑ Patient has had an inadequate response for at least three (3) months (check applicable box(es) below:

❑ oral aminosalicylates	❑ azathioprine	❑ 6-mercaptopurine

AND

❑ Trial and failure of budesonide (9mg daily for 8 weeks) or high doses steroids (40-60 mg prednisone)

(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;~~**12/282017**