

OPTIMA HEALTH PLAN

PHARMACY/MEDICAL 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 1-844-723-2094. 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® ARIA™** (golimumab) (J-1602) (Medical) (*Preferred*)

DRUG INFORMATION: Complete information below. If incomplete, authorization process will be delayed.

Drug Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code: _____

SIMPONI® ARIA™ DOSE _____ FREQUENCY _____

CLINICAL CRITERIA: To qualify, **ALL** appropriate boxes below **must** be checked or authorization process will be delayed.

Prescriber is a Rheumatologist

DIAGNOSIS: Applicable diagnosis below **MUST** be checked to qualify. All chart notes **MUST** be attached to this request or authorization process will be delayed.

Part A - DMARD therapy

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

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

<input type="checkbox"/> Moderate-to-severe Active Rheumatoid Arthritis	<input type="checkbox"/> Active Ankylosing Spondylitis	<input type="checkbox"/> Active Psoriatic Arthritis
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Trial and failure of **at least one DMARD** therapy for **at least three (3) months** (check each tried) (Refer to Part A).

Medication being provided by (check applicable box below):

Location/site of drug administration: _____

NPI or DEA # of administering location: _____

OR

Specialty Pharmacy: PropriumRx

(signature on next page)

****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: _____

Prescriber's DEA OR NPI #: _____

*Approved by Pharmacy and Therapeutics Committee: 1/16/2014

REVISED/UPDATED: 1/27/2014; 2/7/2014; 4/4/2014; 4/28/2014; 10/31/2014; 4/3/2015; 5/23/2015; 12/23/2015; 1/29/2016; 9/28/2016; 12/11/2016; 7/24/2017; 1/1/2018; 3/28/2018; 4/30/2018;