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**_____

Medication is provided by the physician's office.

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

Prescriber is: ❑ **Rheumatologist** ❑ **Gastroenterologist** ❑ **Dermatologist**

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)***:

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

❑ **Moderate-to-severe Active Rheumatoid Arthritis**	❑ **Active Ankylosing Spondylitis**	❑ **Active Psoriatic Arthritis**

❑ Trial and failure of ***at least one DMARD*** therapy for ***at least three (3) months*** ***(check each tried)*** ***(Refer to Part A).***

*****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**: 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**