

# 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 (PHARMACY PREFERRED)**

**DRUG INFORMATION:** Complete information below or 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 will be delayed.

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

### **PART A: DMARD Therapy**

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

<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: _____		

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

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

<input type="checkbox"/> oral aminosalicylates	<input type="checkbox"/> azathioprine	<input type="checkbox"/> 6-mercaptopurine
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### **AND**

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

(Continued on next page; Signature page **MUST** be attached with this request form)

