SENTARA COMMUNITY PLAN
(MEDICAID)

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. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Simponi® (golimumab) **SQ ONLY (Pharmacy Benefit)**

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

Diagnosis	Recommended Quantity Limit
• **Active Ankylosing Spondylitis (AS)**	• Quantity Limit = One, 50mg syringe per 28 days
• **Active Psoriatic Arthritis (PsA) in adults, alone or in combination with methotrexate**	• Quantity Limit = One, 50mg syringe per 28 days
• **Moderately to severely active Ulcerative Colitis**	• Quantity Limit = Three, 100mg syringes allowed in the initial 28 days • One, 100mg syringe per 28 days after induction period
• **Moderately to severely active Rheumatoid Arthritis in adults, in combination with methotrexate**	• Quantity Limit = One, 50mg syringe per 28 days

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CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

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

DIAGNOSIS: Check one of the diagnoses below to ensure authorization will not be delayed.

❑ Rheumatoid Arthritis

❑ Must be in combination with methotrexate

OR

❑ Member has a contraindication or adverse reaction to methotrexate

AND

❑ Trial and failure of at least **ONE (1) other DMARD** therapy **(check each tried)**:

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

AND

❑ Trial and failure of **TWO (2)** of the following:

❑ Humira®	❑ Enbrel®	❑ Infliximab

❑ Psoriatic Arthritis

❑ Member tried and failed of the preferred drugs:

❑ Methotrexate (may be used alone or in combination)

AND

❑ Trial and failure of **TWO (2)** of the following **PREFERRED** drugs below:

❑ Humira®	❑ Enbrel®	❑ Infliximab

❑ Ankylosing Spondylitis

❑ Trial and failure of an adequate trial of at least **TWO (2)** NSAIDs

OR

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- ❑ Use of NSAIDs is contraindicated

AND

- ❑ Trial and failure of, contraindication, or adverse reaction to methotrexate

AND

- ❑ Trial and failure of **TWO (2)** preferred biologics:

❑ Humira®	❑ Enbrel®	❑ Infliximab

❑ Moderate-to-Severe Active Ulcerative Colitis

- ❑ Trial and failure of a compliant regimen of oral or rectal aminosalicylates (i.e., sulfasalazine or mesalamine) for **two (2)** consecutive months

AND

- ❑ Trial and failure of a compliant regimen of oral corticosteroids (for moderate to severe CD) unless contraindicated, or intravenous corticosteroids (for severe and fulminant CD or failure to respond to oral corticosteroids)

AND

- ❑ Trial and failure of a compliant regimen of azathioprine or mercaptopurine for **three (3)** consecutive months

AND

- ❑ Trial and failure of **TWO (2)** of the **PREFERRED** biologics below:

❑ Humira®	❑ Infliximab

Medication being provided by (check box below that applies):

❑ **Physician's office** **OR** ❑ **Specialty Pharmacy - PropriumRx**

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.

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; 11/23/2018; 12/13/2018; (Rev) 4/6/2019; 9/7/2019; 11/23/2020; 7/19/2021; 8/10/2021; 7/11/2022;6/30/2023~~ 11/8/2023, **4/24/2024**