

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: _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

Weight (if applicable): _____ Date weight obtained: _____

Diagnosis	Recommended Quantity Limit
<input type="checkbox"/> Active Ankylosing Spondylitis (AS)	Quantity Limit = One, 50mg syringe per 28 days
<input type="checkbox"/> Active Psoriatic Arthritis (PsA) in adults, alone or in combination with methotrexate	Quantity Limit = One, 50mg syringe per 28 days
<input type="checkbox"/> Moderately to severely active Ulcerative Colitis	<ul style="list-style-type: none"> • ≥40 kg: 200mg at Week 0, then 100 mg at Week 2 followed by 100 mg maintenance therapy every 4 weeks • 15 – 40 kg: 100 mg SC at Week 0, then 50 mg at Week 2 followed by 50 mg maintenance therapy every 4 weeks • Three 50 mg or 100mg syringes allowed in the initial 28 days • One 50 mg or 100mg syringe per 28 days after induction period

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Diagnosis	Recommended Quantity Limit
<input type="checkbox"/> Moderately to severely active Rheumatoid Arthritis in adults, in combination with methotrexate	Quantity Limit = One, 50mg syringe per 28 days

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.

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

Rheumatoid Arthritis

- Member is 18 years of age or older
- Must be in combination with methotrexate

OR

- Member has a contraindication or adverse reaction to methotrexate
- Trial and failure of at least **ONE (1) other DMARD** therapy (**check each tried**):

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

- Trial and failure of **BOTH** preferred drugs below:

<input type="checkbox"/> adalimumab-adbm (Boehringer Ingelheim) OR Hadlima [®] (adalimumab-bwwd)	<input type="checkbox"/> Enbrel [®]
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Psoriatic Arthritis

- Member is 18 years of age or older
- Trial and failure of **TWO (2)** preferred drugs below:

<input type="checkbox"/> adalimumab-adbm (Boehringer Ingelheim) OR Hadlima [®] (adalimumab-bwwd)	<input type="checkbox"/> Enbrel [®]	<input type="checkbox"/> Pyzchiva [®] OR Starjemza [™] (Requires trial and failure of a preferred TNF-alpha inhibitor)
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