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
❑ **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

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Diagnosis	Recommended Quantity Limit
❑ **Moderately to severely active Ulcerative Colitis**	• ≥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
❑ **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
- ❑ Trial and failure of one conventional synthetic disease modifying anti-rheumatic drug (csDMARD) (e.g. methotrexate, azathioprine, hydroxychloroquine, penicillamine, sulfasalazine, leflunomide, etc.)
- ❑ Trial and failure of **BOTH** preferred drugs below:

❑ adalimumab-adbm (Boehringer Ingelheim) **OR** Hadlima® (adalimumab-bwwd)	Enbrel®

❑ Psoriatic Arthritis

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

❑ adalimumab-adbm (Boehringer Ingelheim) **OR** Hadlima® (adalimumab-bwwd)	❑ Enbrel®	❑ Pyzchiva® **OR** Starjemza™ (Requires trial and failure of a preferred TNF-alpha inhibitor)

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❑ Ankylosing Spondylitis

- ❑ Member is 18 years of age or older
- ❑ Trial and failure of **BOTH** preferred drugs below:

❑ adalimumab-adbm (Boehringer Ingelheim) **OR** Hadlima® (adalimumab-bwwd)	Enbrel®

❑ Moderate-to-Severe Active Ulcerative Colitis

- ❑ Member's weight is at least 15kg
- ❑ Trial and failure of **BOTH** of the preferred drugs below:

❑ adalimumab-adbm (Boehringer Ingelheim **OR** Hadlima® (adalimumab-bwwd)	❑ Pyzchiva® **OR** Starjemza™ (Requires trial and failure of a preferred TNF-alpha inhibitor)

Medication being provided by (check applicable box(es) below):

❑ **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/REFORMATTED: ~~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; 4/6/2019; 12/16/2025; 1/21/2026, 2/242026; 3/11/2026;~~ **7/13/2026**