# 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 |
| ❑ **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<br>• 15 – 40 kg: 100 mg SC at Week 0, then 50 mg at Week 2 followed by 50 mg maintenance therapy every 4 weeks<br>• Three 50 mg or 100mg syringes allowed in the initial 28 days<br>• One 50 mg or 100mg syringe per 28 days after induction period |

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| Diagnosis | Recommended Quantity Limit |
|---|---|
| ❑ **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)**:

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

- ❑ 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® (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 a compliant regimen of oral or rectal aminosalicylates (i.e., sulfasalazine or mesalamine) for **two (2)** consecutive months
- ❑ Trial and failure of a compliant regimen of oral corticosteroids (for moderate to severe UC) unless contraindicated, or intravenous corticosteroids (for severe and fulminant UC or failure to respond to oral corticosteroids)
- ❑ Trial and failure of a compliant regimen of azathioprine or mercaptopurine for **three (3)** consecutive months
- ❑ Trial and failure of **BOTH** of the preferred drugs below:

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