

OPTIMA FAMILY CARE MEDALLION 4.0

PHARMACY/MEDICAL PRIOR AUTHORIZATION/STEP-EDIT*

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 1-844-723-2094. 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: **AMEVIVE® (alefacept) (J-0215)** **(Medical)**

DRUG INFORMATION: Complete all information below or authorization process will be delayed.

Drug Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code: _____

CLINICAL CRITERIA: ALL lines MUST be checked to ensure authorization process will NOT be delayed.

- Is prescriber a dermatologist? Yes No
- Does patient have moderate to severe chronic plaque psoriasis? Yes No
- Does the psoriasis involve the following? (**Check all that apply**): Yes No
 - Palms soles face genitalia or greater than 10% of total body surface area
- Tried and failure of at least one therapy AND three Preferred TNFs Yes No
 - UV Light Therapy
 - NB UV-B
 - PUVA
 - Oral Systemic Therapy
 - acitretin
 - methotrexate
 - cyclosporine

AND

- Trial and failure of all three (3): Yes No
 - Enbrel® **AND** Humira® **AND** Remicade®

Medication being provided by a 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.

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

UPDATED: 7/1/2018