

OPTIMA FAMILY CARE MEDALLION 4.0

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. Incomplete form will delay authorization process.

Drug Requested: Siliq™ (brodalumab) SQ Injection

DRUG INFORMATION: Complete information below. If incomplete, authorization process will be delayed

Drug Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

(Package: 210 mg/1.5 mL solution in single-dose prefilled syringe)

LENGTH OF AUTHORIZATION: ONE (1) YEAR

CLINICAL CRITERIA: ALL boxes MUST be checked to qualify. Incomplete information will delay authorization process.

Prescriber is a: Dermatologist Rheumatologist

• Member tried and failed TWO (2) of the PREFERRED biologics below:

Enbrel® Humira®

AND

• Member is \geq 18 years of age;

AND

• Must have tried and failed all other treatments for moderate to severe plaque psoriasis including systematic treatment or phototherapy;

AND

• Had a mental health review and risk assessment for suicidal ideation and behavior

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 #: _____

Revised/Updated: 7/1/2018