OPTIMA FAMILY CARE MEDALLION 4.0

PHARMACY/MEDICAL 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: **Stelara™** (ustekinumab) – **CROHN'S DISEASE**

DRUG INFORMATION: Information below must be completed or authorization process will be delayed.

Drug Form/Strength: ____

Dosing Schedule: ______________________________ **Length of Therapy:** ________________

Diagnosis: ______________________________________ **ICD Code:** ________________

CLINICAL CRITERIA: Check applicable boxes below to qualify. If NOT checked, authorization process will be delayed.

Prescriber is a: ❑ **Gastroenterologist**

❑ **Diagnosis: *Crohn's Disease*:**

❑ Patient tried and failed ***at least one previous 5-Aminosalicylates or Immunomodulators therapy (check each tried):***

❑ methotrexate	❑ azathioprine	❑ auranofin	❑ balsalazide
❑ sulfasalazine	❑ leflunomide	❑ 6-mercaptopurine	❑ oral aminosalicylates
❑ olsalazine	❑ mesalamine ______		

AND

❑ budesonide or high does (40-60 mg prednisone) steroids

AND

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

❑ **Location/site of drug administration**: ❑ **physician's office** **OR** ❑ **Home Infusion**

NPI or DEA # of administering location: ____

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.****

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