

OPTIMA HEALTH FAMILY CARE

(MEDICAID)

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 1-844-723-2094**. 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 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 qualify or authorization process will 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** Renflexis®

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 #: _____