OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(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. **Incomplete form will delay authorization process.**

Drug Requested: Cosentyx® SQ (secukinumab) **(self-administered) (Pharmacy benefit)**

DRUG INFORMATION: Complete information below or authorization will be delayed

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

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

Prescriber is a: ❑ **Dermatologist** ❑ **Rheumatologist**

DIAGNOSIS: Check applicable diagnosis below**.** If **not** checked, authorization will be delayed.

❑ Active Ankylosing Spondylitis

- ❑ Trial and failure of at least 2 NSAIDs

OR

- ❑ Use of NSAIDs is contraindicated in patient

AND

- ❑ **Trial and failure of ONE (1) of the PREFERRED below (check each tried)**:

❑ Humira®	❑ Enbrel®

❑ Active Psoriatic Arthritis

- ❑ Trial and failure of methotrexate;

OR

- ❑ Requested medication will be used in conjunction with methotrexate;

OR

- ❑ Patient has a contraindication to methotrexate (e.g., alcohol abuse, cirrhosis, chronic liver disease, or other contraindication);

AND

(continued on next page)

- ❑ Trial and failure of **ONE (1)** of the **PREFERRED** below **(check each tried):**

❑ Humira®	❑ Enbrel®

❑ Moderate to Severe Chronic Plaque Psoriasis

- ❑ Patient tried and failed **at least one** of either Phototherapy or Alternative Systemic therapy **(check each tried):**

❑ **Phototherapy**

- ❑ **UV Light Therapy**
  - ❑ NB UV-B
  - ❑ PUVA

OR

❑ **Alternative Systemic Therapy**

- ❑ **Oral Alternative Systemic Therapy**
  - ❑ acitretin
  - ❑ methotrexate
  - ❑ cyclosporine

AND

- ❑ Must have a previous failure on a topical psoriasis agent

AND

- ❑ Trial and failure of **ONE (1)** of the **PREFERRED** below:

❑ Humira®	❑ Enbrel®

Medication being provided by a Specialty Pharmacy- Sentara Norfolk General CM Pharmacy

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:** ~~10/31/2018; 11/18/2018;~~ **12/30/2018**;