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: Ilumya™ (tildrakizumab-asmn) **(Pharmacy: Prefilled syringe)**

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

Drug Form/Strength: _____

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

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

SubQ 100mg at weeks 0, 4, and then every 12 weeks thereafter**.**

CLINICAL CRITERIA: **ALL** boxes **MUST** be checked to qualify to ensure authorization will **NOT** be delayed.

Prescriber is: ❑ **Gastroenterologist** **OR** ❑ **Rheumatologist**

DIAGNOSIS: Check the applicable box below to ensure authorization will **NOT** be delayed.

❑ **Moderate to Severe Chronic Plaque Psoriasis**

❑ Patient tried and failed **at least one** of either Phototherapy or Alternative System Therapy for **at least three (3) months (check each tried below)**:

❑ **Phototherapy** **OR** ❑ **Alternative Systemic Therapy**:

❑ **UV Light Therapy** ❑ **Oral Alternative System Therapy**

❑ NB UV-B	❑ acitretin
❑ PUVA	❑ methotrexate
	❑ cyclosporine

AND

❑ Trial and failure of Humira® and Enbrel® for at least 30 days. Paid claims will be verified.

Medication being provided by (check applicable box below):

❑ **Physician's office** **OR** ❑ **Specialty Pharmacy – Sentara Norfolk General CM Pharmacy**

(Continued on next page; signature page MUST be included with request)

(Signature page MUST be attached with request.)

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 #: _____

***Approved by Pharmacy & Therapeutics Committee**: 6/21/2018:
REVISED/UPDATED: 9/26/2018;