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. If information provided is NOT complete, correct, or legible, authorization will be delayed.

Drug Requested: Ilumya™ (tildrakizumab-asmn) **(J3245)**

❑ **Will drug requested below be purchased by the Physician's office?** ❑ **Yes** ❑ **No**
If YES, fax form to Optima Medical Services at 1-844-723-2094

❑ **Will drug requested below be purchased by the member?** ❑ **Yes** ❑ **No**
If YES, fax form to: Optima Pharmacy Department at 1-800-750-9692

Ilumya™ should ONLY be administered by a healthcare provider.

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

Drug Form/Strength: _____

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

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

RECOMMENDED DOSAGE: SubQ 100mg at weeks 0, 4, and then every 12 weeks thereafter.

CLINICAL CRITERIA: Check below **ALL** that apply. **ALL** criteria **must** be met for approval. **ALL** documentation, including lab results and/or chart notes **(when required)**, **must** be provided or request will be denied.

Prescriber is: ❑ **Rheumatologist** **OR** ❑ **Dermatologist**

DIAGNOSIS: Check the applicable box below or authorization will 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

(Continued on next page. Signature page MUST be attached to request form)

AND

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

❑ **Cimzia®**	❑ **Humira®**
❑ **Stelara®**	❑ **Tremfya™**

AND

- ❑ **Cosentyx®**

Medication being provided by (check applicable box below):

❑ **Physician's office** **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 #: _____

***Approved by Pharmacy & Therapeutics Committee**: 6/21/2018;
REVISED/UPDATED: ~~9/26/2018; 10/10/2018; 11/24/2018; 3/31/2019;~~ **(Reformatted) 4/13/2019**;