

OPTIMA HEALTH COMMUNITY 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 1-844-348-3720

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

<input type="checkbox"/> NB UV-B	<input type="checkbox"/> acitretin
<input type="checkbox"/> PUVA	<input type="checkbox"/> methotrexate
	<input type="checkbox"/> 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:

<input type="checkbox"/> Cimzia [®]	<input type="checkbox"/> Humira [®]
<input type="checkbox"/> Stelara [®]	<input type="checkbox"/> 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**