OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA 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 1-800-750-9692.** 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: **Stelara™** (ustekinumab) – **CROHN'S DISEASE**

DRUG INFORMATION: Information below **must** be completed or authorization process will be delayed.

Drug Form/Strength: ______________________________

Dosing Schedule: ______________________ **Length of Therapy:** ______________

Diagnosis: ______________________ **ICD Code:** ______________

CLINICAL CRITERIA: Check applicable boxes below to qualify to ensure authorization will **NOT** be delayed**.**

Prescriber is a: ❑ **Gastroenterologist**

❑ **Diagnosis: Crohn's Disease**:

❑ Patient tried and failed **at least one previous 5-Aminosalicylates or Immunomodulators therapy (check each tried)**:

❑ methotrexate	❑ azathioprine	❑ auranofin	❑ balsalazide
❑ sulfasalazine	❑ leflunomide	❑ 6-mercaptopurine	❑ oral aminosalicylates
❑ olsalazine	❑ mesalamine ______________		

AND

❑ budesonide or high does (40-60 mg prednisone) steroids

AND

Medication being provided by (check applicable box(es) below):

❑ **Location/site of drug administration**: ❑ **physician's office** **OR** ❑ **Home Infusion**

NPI or DEA # of administering location: ______________________________

OR

❑ **Specialty Pharmacy**: **PropriumRx**

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

(continued from previous page)

(Signature page <u>MUST</u> be attached to request.)

<u>Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.</u>

<u>*Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*</u>

Patient Name: ____

Member Optima #: ____________________________________ Date of Birth: ___________________

Prescriber Name: ____

Prescriber Signature: ______________________________________ Date: _____________________

Office Contact Name: ____

Phone Number: __________________________________ Fax Number: _______________________

DEA OR NPI #: ____

REVISED/UPDATED: ~~8/1/2017; 12/28/2017; 5/26/2018; 8/30/2018;~~ **10/8/2018**