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: Tremfya™ (guselkumab) **Injection**

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

Drug Form/Strength: _____

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

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

RECOMMENDED DOSE (Prefilled syringe 100 mg/mL single-use):
100mg at Week 0, Week 4, and every 8 weeks thereafter.

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

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

DIAGNOSIS: Moderate-to-Severe Chronic Plaque Psoriasis

❑ Patient tried and failed **at least ONE (1)** of either **Phototherapy or Alternative System Therapy (check each tried)**:

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

- ❑ **UV Light Therapy**
  - ❑ NB UV-B
  - ❑ PUVA
- ❑ **Oral Alternative Systemic Therapy**
  - ❑ acitretin
  - ❑ methotrexate
  - ❑ cyclosporine

AND

❑ Trial and failure of **ONE (1)** of the following:

❑ Humira®	❑ Enbrel®

Medication being provided by a Specialty Pharmacy - PropriumRx

(Continued on next page; Signature page MUST be attached with this request.)

(Signature page MUST be included 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 #: _____

Revised/Updated: ~~10/31/2018; 11/4/2018;~~ **11/18/2018**;