OPTIMA HEALTH COMMUNITY CARE

PHARMACY/MEDICAL PRIOR AUTHORIZATION/STEP-EDIT*

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 1-844-348-3720. 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: **AMEVIVE®** (alefacept) **(J-0215)** ***(Medical)***

DRUG INFORMATION: Complete information below. If incomplete, authorization process will be delayed.

Drug Form/Strength: _____

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

Diagnosis: _____ **ICD Code:** _____

CLINICAL CRITERIA: ALL lines MUST be checked to qualify or authorization process will be delayed.

- Is prescriber a dermatologist? ❑ Yes ❑ No
- Does patient have moderate to severe chronic plaque psoriasis? ❑ Yes ❑ No
- Does the psoriasis involve the following? ***(Check all that apply)***: ❑ Yes ❑ No
  ❑ Palms ❑ soles ❑ face ❑ genitalia or ❑ greater than 10% of total body surface area
- Tried and failure of ***at least one therapy*** **AND** ***three Preferred TNFs*** ❑ Yes ❑ No

  ❑ **UV Light Therapy**
  - ❑ NB UV-B
  - ❑ PUVA

  ❑ **Oral Systemic Therapy**
  - ❑ acitretin
  - ❑ methotrexate
  - ❑ cyclosporine

AND

- **Trial and failure of *all three* (3):** ❑ Yes ❑ No

  ❑ Enbrel® **AND** ❑ Humira® **AND** ❑ Remicade®

Medication being provided by a 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 #: _____

UPDATED: 8/1/2017