OPTIMA HEALTH COMMUNITY CARE

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. 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.***

CROHN'S DISEASE ONLY

Check Drug Requested Below: ***If not checked, authorization process will be delayed.***

❑ **Stelara™ IV** (ustekinumab) – 1st dose ***(Medical - Physician's Office)***	❑ **Stelara™ SQ** (ustekinumab) - ***Pharmacy (ONLY for established therapy and IV was not given as a "SAMPLE")***

(JCODE Stelara 130mg/26ml SOLN: J3357/NDC 57894-054-27)

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For MEDICAL ONLY (administered in physician's office ONE-TIME ONLY) – Stelara IV therapy:

❑ **Stelara™ IV therapy** - ***Fax form to Optima Medical Services* at 1-844-348-3720**

For PHARMACY ONLY (continuously self-administered by member once IV therapy is approved and IV is NOT given as a "sample"):

❑ **Stelara™ SQ** - ***Fax form to: Optima Pharmacy Department* at 1-800-750-9692**

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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. If NOT checked, authorization process will 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

(continued on next page)

- ❑ Trial and failure of **two (2)** of the following ***PREFERRED*** biologics below (check each tried):

❑ Remicade®	❑ Entyvio®	❑ Cimzia™

(Remicade®, Entyvio®, and Cimzia™ require a Prior Authorization form. Forms can be found at www.Optimahealth.com)

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

❑ **Physician's office one time only** **AND** ❑ **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 #: _____

REVISED/UPDATED: ~~8/1/2017;~~ **12/28/2017**;