OPTIMA HEALTH COMMUNITY CARE

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. 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.***

- ❑ **Will Stelara IV therapy *be administered in the physician's office*?** ❑ **Yes** ❑ **No**
  If YES, fax form to Optima **Medical Services at 1-844-348-3720**
- ❑ **Will Stelara SQ therapy be *self-administered by member*?** ❑ **Yes** ❑ **No**
  If YES, fax form to*: *Optima **Pharmacy Department at 1-800-319-5003**

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

❑ **Stelara™ SQ** (ustekinumab) **(J3357)**	❑ **Stelara™ IV Infusion** (ustekinumab) **(J-3357)**

DRUG INFORMATION: ***Information 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 or incomplete, authorization process will be delayed.***

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

- **Diagnosis** ***(check one (1) that applies):***

❑ **Rheumatoid Arthritis**	❑ **Active Psoriatic Arthritis**
❑ **Ankylosing Spondylitis Arthritis**	❑ **Juvenile Idiopathic Arthritis**
❑ **Plaque Psoriasis**	

❑ Trial and failure of **two (2) TNFs**:

- ❑ **Pharmacy Dept ONLY:** ❑ Enbrel® **AND** ❑ Humira®
- ❑ **Medical Svcs ONLY:** ❑ Remicade® **AND** ❑ Cimzia™

❑ Patient has tried and failed at least ***one DMARD*** for at least three (3) months **AND two (2) TNFs** ***(Check each that has been tried)*:**

- ❑ methotrexate
- ❑ azathioprine
- ❑ auranofin
- ❑ hydroxychloroquine
- ❑ sulfasalazine
- ❑ leflunomide
- ❑ Other: _____

OR

(continued on next page)

Moderate to Severe Chronic Plaque Psoriasis: ***Complete information below. If criteria are NOT met, authorization process will be delayed.***

❑ Weight: _____ lbs or _____ kg

Trial and failure of the following:

❑ Remicade® **AND** ❑ Humira®

PLUS

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

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

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

❑ **Physician's office**

OR

❑ **Specialty Pharmacy:** ❑ **Sentara Norfolk General CM Pharmacy**

*****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;~~ **8/31/2017**;