

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; fax to 1-800-319-5003. 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™ SQ (ustekinumab) (Preferred) (PHARMACY ONLY)

DRUG INFORMATION: Information must be completed or authorization process will be delayed. Stelara SQ therapy is Self-Administered by member.

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: Complete information below. If criteria are **NOT** met, authorization process will be delayed.

Active Psoriatic Arthritis: Please check applicable box(es) below to qualify.

- Patient tried and failed at least **one DMARD** for at least **three (3) months** (Check each tried):

<input type="checkbox"/> methotrexate	<input type="checkbox"/> sulfasalazine	<input type="checkbox"/> azathioprine
<input type="checkbox"/> leflunomide	<input type="checkbox"/> auranofin	<input type="checkbox"/> hydroxychloroquine
<input type="checkbox"/> Other: _____		

Moderate to Severe Chronic Plaque Psoriasis: Please check applicable box(es) below to qualify.

- Weight: _____ lbs **OR** _____ kg

- Patient tried and failed **at least one** of either **Phototherapy** or **Alternative Systemic Therapy** for **at least three (3) months:**

<input type="checkbox"/> <u>Phototherapy</u>	OR	<input type="checkbox"/> <u>Alternative Systemic Therapy</u>
<input type="checkbox"/> <u>Phototherapy</u>		<input type="checkbox"/> Oral Alternative Systemic Therapy
<input type="checkbox"/> NB UV-B		<input type="checkbox"/> acitretin
<input type="checkbox"/> PUVA		<input type="checkbox"/> methotrexate
		<input type="checkbox"/> cyclosporine

(continued on next page)

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 #: _____

REVISED/UPDATED: 8/1/2017; 8/31/2017; 12/27/2017