OPTIMA HEALTH PLAN

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: **Cosentyx® SQ** (secukinumab) ***(self-administered) (Pharmacy)***

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

Drug Form/Strength: ______________________________

Dosing Schedule: ______________________ **Length of Therapy:** ______________

Diagnosis: ______________________ ***ICD Code, if applicable:*** __________

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

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

Diagnosis: ❑ **Ankylosing Spondylitis** ❑ **Psoriatic Arthritis**

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

❑ methotrexate	❑ sulfasalazine	❑ azathioprine
❑ leflunomide	❑ auranofin	❑ hydroxychloroquine
❑ Other: ______________		

AND

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

❑ Enbrel® **AND** ❑ Humira®

Diagnosis: ❑ **Moderate to Severe Chronic Plaque Psoriasis**

❑ **Trial and failure of:**

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

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

AND

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

❑ Enbrel® **AND** ❑ Humira®

(continued on next page)

Choose which Device would be used

- ❑ **Injection**: 150 mg/mL solution in a single-use Sensoready® pen
- ❑ **Injection**: 150 mg/mL solution in a single-use prefilled syringe
- ❑ **Injection**: 150 mg, lyophilized powder in a single-use vial for ***reconstitution for healthcare professional use only***

Medication being provided by a Specialty Pharmacy: ❑ **Briova SpecialtyRx**

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 #: ____

***Approved by Pharmacy and Therapeutics Committee**: 7/16/2015
REVISED/UPDATED: ~~8/11/2015~~; ~~12/27/2015~~; ~~5/6/2016~~; ~~8/9/2016~~; ~~9/22/2016~~; ~~11/17/2016~~; ~~12/12/2016~~; ~~9/13/2017~~; **10/6/2017**;