

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: **Siliq™ (brodalumab) SQ Injection**

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: _____

(Package: 210 mg/1.5 mL solution in single-dose prefilled syringe)

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

Prescriber is a: Dermatologist Rheumatologist

Diagnosis: Moderate to Severe Chronic Plaque Psoriasis

Trial and failure of:

Phototherapy

OR

Alternative Systemic Therapy

UV Light Therapy

Oral Alternative Systemic Therapy

NB UV-B

acitretin

PUVA

methotrexate

cyclosporine

AND

Trial and failure of two (2) TNFs:

Enbrel®

AND

Humira®

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: 8/17/2017

Revised/Updated: 9/28/2017