

OPTIMA HEALTH PLAN

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

- Will **Stelara IV therapy** be administered in the physician's office one time only? Yes No
If YES, fax form to Optima **Medical Services** at **1-844-723-2094**
- Will **Stelara SQ therapy** be continuously self-administered by member? Yes No
If YES, fax form to: Optima **Pharmacy Department** at **1-800-750-9692**

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

Stelara™ IV (ustekinumab)

Stelara™ SQ (ustekinumab)

(JCODE Stelara 130mg/26ml SOLN: J3590 /NDC 57894-054-27)

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 of Crohn's Disease:

Patient has tried and failed at least one previous 5-Aminosalicylates or Immunomodulators therapy

<input type="checkbox"/> methotrexate	<input type="checkbox"/> azathioprine	<input type="checkbox"/> auranofin	<input type="checkbox"/> balsalazide
<input type="checkbox"/> sulfasalazine	<input type="checkbox"/> leflunomide	<input type="checkbox"/> 6-mercaptopurine	<input type="checkbox"/> oral aminosalicylates
<input type="checkbox"/> olsalazine	<input type="checkbox"/> mesalamine _____		

AND

budesonide or high does (40-60 mg prednisone) steroids

AND

The patient has tried and failed two (2) of the following:

Remicade® (infliximab)

Entyvio® (vedolizumab)

Cimzia™ (certolizumab)

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

(signature on next page)

Medication being provided by (Applicable box (es) below **MUST** be checked or authorization process will be delayed):

Physician's office - one time only

AND

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: 10/14/2016

REVISED/UPDATED: ~~1/1/2017~~; ~~9/18/2017~~; 10/7/2017