OPTIMA HEALTH PLAN

MEDICAL/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 1-844-723-2094**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is NOT complete, correct, or legible, authorization will be delayed.**

For Medicare Members: Medicare Coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. Additional indications may be covered at the discretion of the health plan.

Drug Requested: Ilumya™ (tildrakizumab-asmn) **(J3245)**

(Ilumya™ should ONLY be administered by a healthcare provider.)

❑ **URGENT REVIEW. In checking this box, prescriber attests to the fact that by applying the standard review timeframe may seriously jeopardize the member's life, health, or ability to regain maximum function.**

❑ **STANDARD REVIEW**. In checking this box, the timeframe does **NOT** jeopardize the life or health of the member or the member's ability to regain maximum function and would **NOT** subject the member to severe pain.

DRUG INFORMATION: Complete **all** information below or authorization will be delayed.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

RECOMMENDED DOSAGE: SubQ 100mg at weeks 0, 4, and then every 12 weeks thereafter.

CLINICAL CRITERIA: Check below **ALL** that apply. **ALL** criteria **must** be met for approval. To support each line checked, **ALL** documentation, including lab results, diagnostics, and/or chart notes, **must** be provided or request will be denied.

Prescriber is: ❑ **Rheumatologist** **OR** ❑ **Dermatologist**

DIAGNOSIS: Check applicable box below to ensure authorization will **NOT** be delayed.

❑ **Moderate to Severe Chronic Plaque Psoriasis**

❑ Member tried and failed **at least one** of either Phototherapy or Alternative System Therapy for **at least three (3) months (check each tried below)**:

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

(Continued on next page)

❑ **UV Light Therapy**

❑ NB UV-B	❑ acitretin
❑ PUVA	❑ methotrexate
	❑ cyclosporine

❑ **Oral Alternative System Therapy**

AND

❑ Trial and failure of **ONE (1)** of the **PREFERRED** biologics below:

❑ **Cimzia® Lyophilized**	❑ **Renflexis®**

Medication being provided by (check box below that applies):

❑ **Physician's office** **OR** ❑ **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.

Member Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name**:** _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***Approved by Pharmacy & Therapeutics Committee**: 6/21/2018:
REVISED/UPDATED: 9/26/2018; 10/10/2018; 11/24/2018; 3/30/2019; **(Reformatted)** 4/12/2019; 4/23/2019; **7/7/2019**