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**

❑ For Ankylosing Spondylitis and Psoriatic Arthritis, trial and failure of least ***one DMARD*** for ***at least three (3) months*** ***(check each tried)***:

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

AND

DIAGNOSIS: ***Check applicable diagnosis below. If not checked, authorization process will be delayed.***

❑ *Ankylosing Spondylitis*

❑ **Trial and failure of two (2)** of the ***PREFERRED biologics*** below ***(check each tried)***:

❑ Humira®	❑ Cimzia®	❑ Simponi®

❑ *Psoriatic Arthritis*

❑ **Trial and failure of TWO (2)** of the ***PREFERRED biologics*** **below** ***(check each tried)*****:**

❑ Humira®	❑ Cimzia®	❑ Simponi®	❑ Stelara®

❑ *Moderate to Severe Chronic Plaque Psoriasis*

❑ Patient tried and failed ***at least one*** of either Phototherapy or Alternative Systemic therapy for ***at least three (3) months*** ***(check each tried)*****:**

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

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

(continued on next page)

AND

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

❑ Humira®	❑ Stelara®	❑ Tremfya™

Medication being provided by a Specialty Pharmacy (check applicable box below):

For Optima Commercial Members:

- ❑ **PropriumRx**

For Optima Family Care Members:

- ❑ **Sentara Norfolk General CM Pharmacy**

*****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~~; ~~12/11/2016~~; ~~8/3/2017~~; **12/16/2017**