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®

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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 (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**