

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: Ilumya™ (tildrakizumab-asmn) (Pharmacy, Prefilled syringe)

DRUG INFORMATION: Complete 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: **ALL** boxes **MUST** be checked to qualify to ensure authorization will **NOT** be delayed.

Prescriber is: Rheumatologist **OR** Dermatologist

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

Moderate to Severe Chronic Plaque Psoriasis

Patient 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:
 UV Light Therapy Oral Alternative System Therapy

<input type="checkbox"/> NB UV-B	<input type="checkbox"/> acitretin
<input type="checkbox"/> PUVA	<input type="checkbox"/> methotrexate
	<input type="checkbox"/> cyclosporine

AND

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

<input type="checkbox"/> Cimzia®	<input type="checkbox"/> Humira®
<input type="checkbox"/> Stelara®	<input type="checkbox"/> Tremfya™

AND

Cosentyx®

Medication being provided by (check applicable box below):

Physician's office **OR** Specialty Pharmacy - PropriumRx

(Continued on next page. Signature page **MUST** be attached to request form)

(Signature page **MUST** be included with request.)

****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 & Therapeutics Committee: 6/21/2018:

REVISED/UPDATED: 9/26/2018;10/10/2018; 11/24/2018