# 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:** _____

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**

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

**AND**

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

| | |
|---|---|
| ❑ Cosentyx® | ❑ Humira® |
| ❑ Stelara® | ❑ Tremfya™ |

**Medication being provided by (check applicable box below):**

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

**(Continued on next page; signature page MUST be included with request)**

**(Signature page MUST be attached 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**