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: **Siliq™** (brodalumab) ***Injection***

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:*** _____

(Package: 210 mg/1.5 mL solution in single-dose prefilled syringe)

CLINICAL CRITERIA: ALL boxes MUST be checked to qualify. Incomplete information will delay authorization process.

Prescriber is a: ❑ **Dermatologist** ❑ **Rheumatologist**

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®

Medication being provided by a 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.****

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**: 8/17/2017
Revised/Updated: 9/28/2017