OPTIMA HEALTH PLAN

PHARMACY/MEDICAL 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. 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.***

CROHN'S DISEASE ONLY

❑ ***Will Stelara IV therapy be administered in the physician's office one time only?*** ❑ **Yes** ❑ **No**

If YES, fax form to Optima Medical Services at **1-844-723-2094**

❑ ***Will Stelara SQ therapy be continuously self-administered by member?*** ❑ **Yes** ❑ **No**

If YES, fax form to: Optima Pharmacy Department at **1-800-750-9692**

Check Drug Requested Below: ***If not checked, authorization process will be delayed.***

❑ **Stelara™ IV** (ustekinumab)	❑ **Stelara™ SQ** (ustekinumab)

(JCODE Stelara 130mg/26ml SOLN: J3590 /NDC 57894-054-27)

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DRUG INFORMATION: ***Information below must be completed or authorization process will be delayed.***

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

CLINICAL CRITERIA: ***Check applicable boxes below to qualify. If NOT checked, authorization process will be delayed.***

Prescriber is a: ❑ **Gastroenterologist**

❑ Diagnosis of **Crohn's Disease**:

❑ Patient has tried and failed ***at least one previous 5-Aminosalicylates or Immunomodulators therapy***,

❑ methotrexate	❑ azathioprine	❑ auranofin	❑ balsalazide
❑ sulfasalazine	❑ leflunomide	❑ 6-mercaptopurine	❑ oral aminosalicylates
❑ olsalazine	❑ mesalamine _____		

AND

❑ budesonide or high does (40-60 mg prednisone) steroids

AND

❑ **The patient has tried and failed two (2) of the following:**

❑ Remicade® (infliximab) ❑ Entyvio® (vedolizumab) ❑ Cimzia™ (certolizumab)

(Remicade®, Entyvio®, and Cimzia™ require a Prior Authorization form. Forms can be found at www.Optimahealth.com)

(signature on next page)

***Medication being provided by (applicable box(res) below MUST be checked or authorization process will be delayed)*:**

- ❑ **Physician's office one time only**

  OR

- ❑ **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**: 10/14/2016
REVISED/UPDATED: ~~12/28/2016; 8/6/2017;~~ **9/18/2017**;