

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; 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: Stelara™ (ustekinumab) – CROHN'S DISEASE

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: Crohn's Disease:

Patient tried and failed **at least one previous 5-Aminosalicylates or Immunomodulators therapy (check each tried):**

<input type="checkbox"/> methotrexate	<input type="checkbox"/> azathioprine	<input type="checkbox"/> auranofin	<input type="checkbox"/> balsalazide
<input type="checkbox"/> sulfasalazine	<input type="checkbox"/> leflunomide	<input type="checkbox"/> 6-mercaptopurine	<input type="checkbox"/> oral aminosalicylates
<input type="checkbox"/> olsalazine	<input type="checkbox"/> mesalamine _____		

AND

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

Medication being provided by (check applicable box below):

Location/site of drug administration: physician's office OR Home Infusion
NPI or DEA # of administering location: _____

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; 12/28/2017; 5/9/2018