

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.

Will Stelara IV therapy be administered in the physician's office? Yes No
If YES, fax form to Optima Medical Services at 1-844-723-2094

Will Stelara SQ therapy be 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™ SQ (ustekinumab) (J3357) **Stelara™ IV Infusion** (ustekinumab) (J-3357)

DRUG INFORMATION: Information 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 or incomplete, authorization process will be delayed.

• Prescriber is a: Dermatologist Rheumatologist

• Diagnosis: Active Psoriatic Arthritis

Patient has tried and failed at least one DMARD for at least three (3) months AND two (2) TNFs (Check each that has been tried):

<input type="checkbox"/> methotrexate	<input type="checkbox"/> sulfasalazine	<input type="checkbox"/> azathioprine
<input type="checkbox"/> leflunomide	<input type="checkbox"/> auranofin	<input type="checkbox"/> hydroxychloroquine
<input type="checkbox"/> Other: _____		

AND

Trial and failure of two (2) TNFs:

Pharmacy Dept ONLY: Enbrel® AND Humira®

Medical Svcs ONLY: Remicade® AND Cimzia™

OR

(continued on next page)

Moderate to Severe Chronic Plaque Psoriasis: Complete information below. If criteria are **NOT met, authorization process will be delayed.**

- Weight: _____ lbs **OR** _____ kg
- Patient has tried and failed at least one of either **Phototherapy** or **Alternative Systemic Therapy** for at least three (3) months **AND** **two (2) TNFs:**
 - 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:**
 - Pharmacy Dept ONLY:** Enbrel® **AND** Humira®
 - Medical Svcs ONLY:** Remicade® **AND** Cimzia™

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

- Physician's office

OR

- Specialty Pharmacy:

For Optima Commercial Members:

- PropriumRx

For Optima Medicaid Members:

- Sentara Norfolk General CM Pharmacy

****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: 4/21/2010; 7/22/2016

REVISED/UPDATED: 10/28/2014; 12/2/2014; 1/15/2015; 5/22/2015; 12/29/2015; 7/22/2016; 8/11/2016; 9/22/2016; 12/16/2016; 1/31/2017; 7/24/2017; 9/1/2017; 10/10/2017.