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) ***(PHARMACY ONLY) (PREFERRED)***

DRUG INFORMATION: ***Information must be completed or authorization process will be delayed.***
Stelara SQ therapy is Self-Administered by member.

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** ❑ **Gastroenterologist**

Diagnosis: ***Complete information below. If criteria are NOT met, authorization process will be delayed.***

❑ ***Active Psoriatic Arthritis:*** ***Please check applicable box(es) below to qualify.***

❑ Patient tried and failed at least ***one DMARD*** for at least ***three (3) months*** (***Check each that has been tried):***

❑ methotrexate	❑ sulfasalazine	❑ azathioprine
❑ leflunomide	❑ auranofin	❑ hydroxychloroquine
❑ Other: _____		

❑ ***Moderate to Severe Chronic Plaque Psoriasis:*** ***Please check applicable box(es) below to qualify.***

❑ Weight: _____ lbs **OR** _____ kg

❑ Patient tried and failed ***at least one*** of either **Phototherapy or Alternative Systemic Therapy** for ***at least three (3) months:***

❑ **Phototherapy**	**OR**	❑ **Alternative Systemic Therapy**
❑ **Phototherapy**		❑ **Oral Alternative Systemic Therapy**
❑ NB UV-B		❑ acitretin
❑ PUVA		❑ methotrexate
		❑ cyclosporine

❑ ***Crohn's Disease:*** ***Please check applicable box(es) below to qualify.***

❑ **Patient has been diagnosed with Crohn's Disease**

❑ Patient tried and failed ***at least one previous 5-Aminosalicylate or Immunomodulator therapy for at least three (3) months (check each tried):***

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

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AND

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

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

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**: ~~1/21/2010~~; 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~~; ~~12/16/2017~~; **3/31/2018**