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: Tremfya™ (guselkumab) **Injection (Preferred)**

DRUG INFORMATION: Complete information below or authorization will be delayed

Drug Form/Strength: _____

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

Diagnosis: _____ **ICD Code, if applicable:** _____

RECOMMENDED DOSE (Prefilled syringe 100 mg/mL single-use):
100mg at Week 0, Week 4, and every 8 weeks thereafter.

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

Prescriber is a Dermatologist

DIAGNOSIS: Moderate-to-Severe Chronic Plaque Psoriasis

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

❑ **Phototherapy**
- ❑ **UV Light Therapy**
  - ❑ NB UV-B
  - ❑ PUVA

OR

❑ **Alternative Systemic Therapy**
- ❑ **Oral Alternative Systemic Therapy**
  - ❑ acitretin
  - ❑ methotrexate
  - ❑ cyclosporine

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: ~~12/30/2017~~; **12/30/2018**