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. If incomplete, authorization process 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** ❑ **Rheumatologist**

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** **OR** ❑ **Alternative Systemic Therapy**

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