SENTARA COMMUNITY PLAN
(MEDICAID)

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. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Selarsdi® SQ (ustekinumab-aekn) (PHARMACY BENEFIT ONLY)
(Selarsdi SQ therapy is Self-Administered by member)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

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

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

Weight (if applicable): _____ **Date weight obtained:** _____

Recommended Dose:

Indication	Dosage:
Adults with Moderate to Severe Chronic Plaque Psoriasis	**Weight** • Less than or = 100 kg Initial (two 45 mg prefilled syringe/ 28 days) then continue with one 45 mg prefilled syringe/84 days • Greater than 100 kg Two 90 mg administered prefilled syringe/ 28 days then, one 90 mg administered prefilled syringe/ 84 days

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Indication	Dosage:
Adolescent patients (6 years or older) with Moderate to Severe Chronic Plaque Psoriasis	**6 years and older SQ** • Less than or = 60 kg (0.75 mg/kg) dosing down to 15 kg • ≥ 60 to ≤ 100 kg • Initial (two 45 mg prefilled syringe/ 28 days) then continue with one 45 mg prefilled syringe/ 84 days • Greater than 100 kg Two 90 mg administered prefilled syringe/ 28 days, then one 90 mg
Active Psoriatic Arthritis	• Two 45 mg prefilled syringe/28 days; then continue with one 45 mg prefilled syringe/ 84 days

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Prescriber is a: ❑ **Dermatologist** ❑ **Rheumatologist**

Diagnosis: Check below diagnosis that applies to qualify for approval or authorization may be delayed.

❑ Active Psoriatic Arthritis

❑ Member tried and failed at least **one DMARD** **(Check each tried):**

❑ methotrexate	❑ sulfasalazine	❑ azathioprine
❑ leflunomide	❑ auranofin	❑ hydroxychloroquine

AND

❑ Patient has tried and failed **TWO (2)** of the following biologics:

❑ Humira®	❑ Enbrel®	❑ Infliximab

❑ Moderate to Severe Chronic Plaque Psoriasis

❑ Member is 6 years or older with moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy.

AND

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- ❑ Trial and failure of, contraindication, or adverse reaction to methotrexate

AND

- ❑ Trial and failure of **TWO (2)** of the **PREFERRED** drugs below:

❑ Humira®	❑ Enbrel®	❑ Infliximab

Medication being provided by Specialty Pharmacy - PropriumRx

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*

Previous therap-ies will be verified through pharmacy paid claims or submitted chart notes.