

# OPTIMA FAMILY CARE MEDALLION 4.0

## 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:**     **Oral Hypoglycemics with Metformin Step Edit (MEDICAID)**

Applicable box(es) below **MUST** be checked to qualify:

PREFERRED	Non-Preferred
<b>Alpha-Glucosidase Inhibitors</b>	
<input type="checkbox"/> Acarbose	<input type="checkbox"/> Glyset <input type="checkbox"/> Miglitol (generic Glyset) <input type="checkbox"/> Precose
<b>DPP-IV Inhibitors and Combination</b>	
<input type="checkbox"/> Janumet <input type="checkbox"/> Janumet XR <input type="checkbox"/> Januvia <input type="checkbox"/> Jentadueto <input type="checkbox"/> Tradjenta	<input type="checkbox"/> Alogliptin (generic Nesina) <input type="checkbox"/> Alogliptin/pioglitazone (generic Oseni) <input type="checkbox"/> Alogliptin/metformin (generic Kazano) <input type="checkbox"/> Jentadueto XR <input type="checkbox"/> Kazano <input type="checkbox"/> Kombiglyze XR <input type="checkbox"/> Nesina <input type="checkbox"/> Onglyza <input type="checkbox"/> Oseni
<b>Meglitinides</b>	
<input type="checkbox"/> Repaglinide <input type="checkbox"/> Nateglinide	<input type="checkbox"/> Prandin <input type="checkbox"/> PrandiMet <input type="checkbox"/> Repaglinide/metformin <input type="checkbox"/> Starlix
<b>Second Generation Sulfonylureas</b>	
<input type="checkbox"/> Glimepiride <input type="checkbox"/> Glipizide <input type="checkbox"/> Glipizide ER <input type="checkbox"/> Glyburide <input type="checkbox"/> Glyburide micronized	<input type="checkbox"/> Amaryl <input type="checkbox"/> Diabeta <input type="checkbox"/> Glucotrol <input type="checkbox"/> Glucotrol XL <input type="checkbox"/> Glynase
<b>Thiazolidinediones</b>	
<input type="checkbox"/> Pioglitazone	<input type="checkbox"/> Avandia <input type="checkbox"/> Actoplus Metformin IR & XR <input type="checkbox"/> Actos <input type="checkbox"/> Avandaryl <input type="checkbox"/> Avandamet <input type="checkbox"/> Duetact <input type="checkbox"/> Pioglitazone/metformin <input type="checkbox"/> Pioglitazone/glimepiride

**Drug Information:** Complete information below to qualify or authorization process will be delayed.

**Drug Name/Form/Strength:** \_\_\_\_\_

**Dosing Schedule:** \_\_\_\_\_     **Length of Therapy:** \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_     **ICD Code, if applicable:** \_\_\_\_\_

*(continued on next page)*

**Clinical/Step-Edit Criteria for ALL Preferred and Non-Preferred Oral Hypoglycemics. Boxes must be checked to qualify or authorization process will be delayed.**

Patient is a newly diagnosed Type II Diabetic:  Yes **OR**  NO

**AND**

If **YES** the following criteria must be met: Please complete the following information to qualify:

HgbA1c: \_\_\_\_\_ **AND** Date \_\_\_\_\_

<input type="checkbox"/> Patient has a Hemoglobin A1c <9%	<input type="checkbox"/> Patient has a Hemoglobin A1C ≥ 9%
<input type="checkbox"/> Patient has tried and failed at least 90 days of therapy with metformin unless contraindicated*	<input type="checkbox"/> Patient is on metformin unless contraindicated* plus a second agent (e.g., DPP-IV, SGLT2, GLP-1 receptor agonists, TZDs, sulfonylureas)

**\*Contraindications include:**

- Severe renal impairment (eGFR below 30ml/min/1.73m2)
- Known hypersensitivity
- Acute or chronic metabolic acidosis including diabetic ketoacidosis

**\*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 #: \_\_\_\_\_

REVISED/UPDATED: 7/1/2018