# 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: Symfi Lo™** (efavirenz, lamivudine and tenofovir disoproxil fumarate) ***(MEDICAID)***

***DRUG INFORMATON: Complete all information below or authorization process will be delayed.***

**Drug Form:** ______________________________ **Strength:** ______________________

**Dosing Schedule:** ______________________________ **Length of Therapy:** ______________________

**Diagnosis:** ______________________________ ***ICD Code, if applicable:*** ______________________

***CLINICAL CRITERIA: ALL boxes must be checked to qualify to ensure authorization process will NOT be delayed. Authorization approval: 1 year.***

1) Does member have a diagnosis of HIV? ❑ Yes ❑ No

**AND**

2) Does member weigh ≥ 35 kg? ❑ Yes ❑ No

**AND**

3) Member will be tested for hepatitis B infection prior to initiation of therapy. ❑ Yes ❑ No

**AND**

4) Does member have a creatinine clearance (CrCl) ≥ 50 mL/min within the last 30 days? ❑ Yes ❑ No

**AND**

5) Member does ***NOT*** have moderate to severe hepatic impairment (Child Pugh B or C). ❑ Yes ❑ No

**AND**

6) Member is ***NOT*** on other antiretroviral treatment (ART) medications. ❑ Yes ❑ No

**AND**

7) Member is ***NOT*** on concurrent elbasvir and/or grazoprevir. ❑ Yes ❑ No

*****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**