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 forms will delay the authorization process.***

Drug Requested: Cerdelga™ (eliglustat) capsules

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

Drug Form/Strength/Quantity per Day: _____

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

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

***CLINICAL CRITERIA*: To receive a ONE (1) year approval for this drug, ALL appropriate boxes below must be checked to ensure the authorization process will NOT be delayed.**

- **Does member meet the following criteria?**
  - Is member 18 years of age or older? ❑ Yes ❑ No
  - Diagnosis of Gaucher disease type 1 ❑ Yes ❑ No
  - An FDA-cleared test for determining CYP2D6 genotype has been performed? ❑ Yes ❑ No
    - Indicate genotype test results:
      - Extensive metabolizer (EM)? ❑ Yes ❑ No
      - Intermediate metabolizer (IM)? ❑ Yes ❑ No
      - Poor metabolizer (PM)? ❑ Yes ❑ No
      - Ultra-rapid metabolizer? ***(Cerdelga use not recommended)*** ❑ Yes ❑ No
      - Indeterminate metabolizer? ***Cerdelga use not recommended)*** ❑ Yes ❑ No

MEDICAL NECESSITY*: *Provide clinical evidence/chart notes/documentation that support the use of the requested medication and attach to this request.

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*****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