

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 the authorization process.*

Drug Requested: *Chronic GI Motility Drugs (MEDICAID)*

DRUG INFORMATION: Check box(es) that apply or authorization process will be delayed.

Preferred Medication must be tried and failed 1st	Non-Preferred Medications
<input type="checkbox"/> Amitiza® (lubiprostone) OR <input type="checkbox"/> Linzess® (linaclotide) OR <input type="checkbox"/> Movantik®	<input type="checkbox"/> Lotronex® <input type="checkbox"/> Relistor® <input type="checkbox"/> Trulance™ <input type="checkbox"/> Viberzi™ <input type="checkbox"/> Symproic®

Drug Name/Form: _____ **Strength:** _____
Dosing Frequency: _____ **Length of Therapy:** _____
Diagnosis: _____ **ICD Code, if applicable:** _____

DIAGNOSIS AND MEDICAL INFORMATION: ALL information **MUST** be checked to qualify.

Does the patient have any of the following diagnoses? Please check **ALL** that apply.

- Idiopathic Chronic Constipation (ICC) Yes No
 - Constipation Predominant Irritable Bowel Syndrome (IBS-C) Yes No
 - Severe Diarrhea Predominant Irritable Bowel Syndrome (IBS-D) Yes No
 - Opioid Induced Constipation in chronic NON-cancer pain (OIC) Yes No
 - Other: _____ Yes No
- 1) Amitiza® / Linzess® / Trulance™: Has the patient had a treatment failure on at least **TWO (2)** of the following classes?
Osmotic Laxatives (i.e., lactulose, polyethylene glycol, sorbitol), Bulk forming Laxatives (i.e. psyllium, fiber) **OR** Stimulant Laxatives (i.e. bisacodyl, senna)? Yes No
- 2) Amitiza® / Movantik® / Symproic® (**OIC only**): Has the patient had treatment failure on both polyethylene glycol AND lactulose? Yes No
- 3) Lotronex® / Viberzi™: Has the patient had a treatment failure on at least **THREE (3)** of the following classes?
Bulk forming Laxatives (i.e. psyllium, fiber), Antispasmodic Agents (i.e. dicyclomine, hyoscyamine) **OR** Antidiarrheal Agents (i.e. loperamide, diphenoxylate/atropine, codeine)? Yes No

List pharmaceutical agents attempted and outcome:

1. _____
2. _____

MEDICAL NECESSITY: Provide clinical evidence that the **Preferred** drugs will **NOT** provide adequate benefit.

****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 #: _____ Member Date of Birth: _____
 Prescriber Name: _____
 Prescriber Signature: _____ Date: _____
 Office Contact Name: _____
 Phone Number: _____ Fax Number: _____
 DEA OR NPI #: _____