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: ***(Please check applicable drug below)*** ***(MEDICAID)***

❑ **Juxtapid**® (lomitapide) capsules	❑ **Kynamro**® (mipomersen sodium) Inj

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

Dosage Name/Form: ______________________ **Strength:** ______________________

Quantity per Day: ______________________ **Length of Therapy:** ______________________

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

CLINICAL CRITERIA: Check applicable box (es) below to ensure authorization will NOT be delayed.

- Does the patient have a diagnosis of homozygous familial hypercholesterolemia (HoFH)? ❑ Yes ❑ No
- Is the patient at least 18 years of age? ❑ Yes ❑ No
- Is the prescribing provider certified with the applicable REMS program? ❑ Yes ❑ No
- Has the patient had a treatment failure, maximum dosing with or contraindication to: statins, ezetimibe, niacin, fibric acid derivatives, omega-3 agents and bile acid sequestrants? ❑ Yes ❑ No
- List previous medications (include drug name/dose): ______________________

____

____

____

*****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: ______________________

Physician Name: ______________________

Physician Signature: ______________________ Date: ______________________

Office Contact Name: ______________________

Phone Number: ______________________ Fax Number: ______________________

DEA OR NPI #: ______________________

REVISED/UPDATED: 7/1/2018