

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: Mytesi™ (crofelemer) (formerly Fulyzaq®)

DRUG INFORMATION: Complete information below. If incomplete, authorization process will be delayed.

Drug Name/Form/Strength: _____
Dosing Schedule: _____ Length of Therapy: _____
Diagnosis: _____ ICD Code, if applicable: _____
Quantity per Day: _____

CLINICAL CRITERIA: To receive a **THREE (3) month approval**, boxes **MUST** be checked to qualify or authorization process will be delayed.

- Is member 18 years of age or older? Yes No
- Does member have diagnosis of HIV/AIDS? Yes No
- Is member currently on anti-retroviral therapy? Yes No
- What antidiarrheal(s), if any, has member tried? Please list names:

- Has infectious diarrhea been ruled out? Yes No
- Does member have any other GI conditions or medications that can cause diarrhea? 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