

# 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:** Triumeq® (abacavir/dolutegravir/lamivudine)

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

➤ Does member meet the following criteria?

- Is member 18 years of age or older?  Yes  No
- Screening results for HLA-B 5701 allele:
  - HLA-B 5701 allele absent?  Yes  No

**NOTE:** Triumeq® is **contraindicated** in patients who are positive for this allele

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**\*\*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 #: \_\_\_\_\_