OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

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. **If information provided is NOT complete, correct, or legible, authorization can be delayed.**

DRUG REQUESTED: Arikayce® (amikacin liposome inhalation suspension)

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

Drug Form/Strength: _____

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

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

Quantity limit: 590 mg/8.4 mL (28 vials)/28 days

CLINICAL CRITERIA: Check below **ALL** that apply. **ALL** criteria **must** be met for approval. **ALL** documentation, including lab results and/or chart notes **(when required)**, **must** be provided or request will be denied.

Initial Authorization Approval – 12 months

- ❑ Member is ≥ 18 years of age;

AND

- ❑ Diagnosis of Mycobacterium avium complex (MAC) lung disease as determined by the following:
  - ❑ Chest radiography or high-resolution computed tomography (HRCT) scan;

AND

  - ❑ At least two (2) positive sputum cultures;

AND

  - ❑ Other conditions such as tuberculosis and lung malignancy have been ruled out;

AND

- ❑ Member has failed a multi-drug regimen with a macrolide (clarithromycin or azithromycin), rifampin, and ethambutol. **(Failure is defined as continual positive sputum cultures for MAC while adhering to a multi-drug treatment regimen for a minimum duration of 6 months)**;

AND

(Continued on next page)

- ❑ Member has documented failure or intolerance to aerosolized administration of amikacin solution for injection, including pretreatment with a bronchodilator;

AND

- ❑ Arikayce will be prescribed in conjunction with a multi-drug antimycobacterial regimen.

Medication being provided by a Specialty Pharmacy - PropriumRx

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: 6/14/2019