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. **Incomplete forms will delay the authorization process**.

Drug Requested: Cerdelga™ (eliglustat) capsules

DRUG INFORMATION: Complete information below or 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
  - Diagnosis of Gaucher disease type 1 ❑ Yes ❑ No
  - An FDA-cleared test for determining CYP2D6 genotype has been performed? ❑ Yes ❑ No
    - Indicate genotype test results:
      - Extensive metabolizer (EM)? ❑ Yes ❑ No
      - Intermediate metabolizer (IM)? ❑ Yes ❑ No
      - Poor metabolizer (PM)? ❑ Yes ❑ No
      - Ultra-rapid metabolizer? **(Cerdelga use not recommended)** ❑ Yes ❑ No
      - Indeterminate metabolizer? **(Cerdelga use not recommended)** ❑ Yes ❑ No

MEDICAL NECESSITY: Provide clinical evidence/chart notes/documentation that support the use of the requested medication; attach to this request. If not completed, authorization process will be delayed.

_____

_____

_____

(continued on next page; signature MUST be provided with this request)

(Signature page; this MUST be included with the 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 #: _____

REVISED/UPDATED: ~~12/23/2017;~~ **8/17/2018**;